Washington State Responds

Providing Educational Information on HIV/AIDS & Other Infectious Diseases and Reproductive Health

November 2004

Table of Contents

The Washington State Department of Health HIV Prevention & Education Services, Client Services, and the Governor's Advisory Council on HIV/AIDS (GACHA) share a web address. Go to www.doh.wa.gov/hiv.htm for program access. You can also access the HIV Prevention & Education Services website at the old web address: www.doh.wa.gov/cfh/hiv_aids/prev_edu/.

Washington State Responds Quarterly Newsletter Now Electronically Distributed

Now that WSR is distributed electronically on our web site, we can send you an e-mail notification when the new issue is available online. In order to receive this notice please send your e-mail address with the subject title: WSR E-List. All you need to include in your note is your complete e-mail address. Please send to: barbara.schuler@doh.wa.gov.

HIV/AIDS Trainings to Meet State Licensing Requirements

Location	Phone Number	2, 4 or 7 hour Courses	Cost	Other Details
Anacortes (Skagit County)	(360) 299-1342 Jo Ann Hoover	4 hour 7 hour Video Courses	No charge	Offered by Island Hospital. For residents of Island, Skagit and San Juan Counties only.
Bellingham (Whatcom Co.)	(360) 733-3290	2.5 hour 4 hour 7 hour	$25 for 2.5 hr $40 for 4 hour $60 for 7 hour	Offered by the Whatcom County-Bellingham American Red Cross.
Bellingham (Whatcom Co.)	(360) 715-8350	2 hour 4 hour 7 hour	$20 for 2 hour $30 for 4 hour $50 for 7 hour	Offered quarterly through Bellingham Technical College.
Bellingham (Whatcom Co.)	(360) 715-8350	4 hour Infectious Disease Prevention for EMS	$30 for 4 hour	Offered quarterly through Bellingham Technical College.
Bremerton (Kitsap County)	(360) 377-7307	2.5 hour 4 hour 7 hour	$17.50 for 2.5 $25 for 4 hour $30 for 7 hour	Offered by Kitsap Home Care Services Training Center.
Bremerton (Kitsap County)	(360) 475-7359	2 hour	$10 for 2 hour	Offered by Olympic College in Bremerton.
Bremerton (Kitsap County)	(360) 377-3761	2.5 hour 4 hour 7 hour	$21 for 2.5 hr $38 for 4 hour $65 for 7 hour	Offered by the American Red Cross.
Bremerton (Kitsap and Pierce Counties)	(360) 405-0430 (253) 474-5879	2 hour 4 hour	$15 for 2 hour $15 for 4 hour	Offered by instructor Francis Hall. Also available in Pierce County.
Clallam County (Forks/Pt. Angeles)	(360) 374-5288 lanajrm@centurytel.net	3 hour 4 hour 7 hour	$25 for 3 hour $35 for 4 hour $55 for 7 hour	Offered by Olympic Community Health Associates. Scholarships available.
Clallam County (Port Angeles)	(360) 417-2352 K. McDaniel	2 hour	$10 for 2 hour	Offered by Clallam County Health Department.
Clark County (Vancouver)	(360) 693-5821	2 hour 4 hour 7 hour	$10 for 2 hour $20 for 4 hour $50 for 7 hour	Offered by the American Red Cross.
Colville (Ferry, Stevens and Pend Oreille Counties)	1-800-827-3218 Angie	2 hour 4 hour	No cost for 2 or 4 hour classes	Offered by Northeast Tri-County Health District.
Cowlitz County	(360) 414-5599	2 hour 4 hour 7 hour	$10 for 2 hour $30 for 4 hour $45 for 7 hour	Offered by Cowlitz County Health Department.
Coupeville (Island County)	(360) 678-5151	4 hour 7 hour	Call for info	Offered by Island County Health Department and Whidbey General Hospital.
Edmonds (Snohomish County)	(425) 640-1840	7 hour	$68 for 7 hour Also receive one credit.	Offered by Edmonds Community College.

HIV/AIDS TRAININGS TO MEET STATE LICENSING REQUIREMENTS, CONTINUED

Location	Phone Number	2, 4 or 7 hour Courses	Cost	Other Details
Everett (Snohomish County)	(425)–259-9899 Anne Miles; Ext. 16 http:// www.pwnetwork.org/	2 hour 4 hour 7 hour	$20 for 2 hour $30 for 4 hour $50 for 5 hour	Offered by Positive Women's Network.
Everett (Snohomish County)	(425) 252-4103 Laura; Ext.12	2.5 hour 4 hour 7 hour	$25 for 2.5 hour $30 for 4 hour $60 for 7 hour	Offered by the American Red Cross. Scholarships are available.
Grays Harbor	(360) 533-3431	4 hour	$30 for 4 hour	Offered by the American Red Cross.
Grays Harbor and Pacific County	(360) 267-3404 (360) 267-3405	2 hour 4 hour 7 hour 10 hour	$25 for 2 hour $35 for 4 hour $55 for 7 hour $85 for 10 hr	Offered by Critical Incident Stress Management (CISM). They also offer First Aid/CPR classes.
Ilwaco (Pacific County)	(360) 642-2869 Lynn Roy	4 hour 7 hour	Cost varies	Offered by Ocean Beach Hospital.
Kirkland (King County)	(425) 739-8104 (425) 739-8112	7 hour	$69 for 7 hour	Offered by Lake Washington Technical College.
Mason County	(360) 352-8575	4 hour	$30 for 4 hour	Offered by the American Red Cross.
Mt. Vernon (Skagit County)	(360) 428-2151	4 hour 7 hour Videos	$25 handling fee for video tapes	Offered by Skagit Valley Hospital.
Mt. Vernon (Skagit County)	(360) 424-5291	2.5 hour 4 hour 7 hour	$25 for 2.5 hr $35 for 4 hour $45 for 7 hour	Offered by American Red Cross.
Okanogan	(509) 422-7153 Corina	2 hour 4 hour 7 hour	$10 for 2 hour $20 for 4 hour $35 for 7 hour	Offered by Okanogan Health District.
Olympia (Thurston County)	(360) 352-8575	4 hour	$30 for 4 hour	Offered by the American Red Cross.
Olympia	(360) 352-2375	4 hour 7 hour	$30 for 4 hour $60 for 7 hour	Offered by United Communities AIDS Network (UCAN).
Puyallup (Pierce County)	(253) 841-3311	2 hour 4 hour 7 hour	$15 for 2 hour $40 for 4 hour $50 for 7+ hour	Offered by H.E.L.P. (HIV/AIDS Educational Learning Place) the C.P.R. First Aid Company.
San Juan County	(360) 378-4474	2 hour 4 hour 7 hour	No charge for Island, Skagit and San Juan Counties	Offered by San Juan County Health & Community Services.

HIV/AIDS Trainings to Meet State Licensing Requirements, continued

Location	Phone Number	2, 4 or 7 hour Courses	Cost	Other Details
Seattle/King Co. & So. Snohomish Co.	(206) 784-5655 www.healthinfonetwork.org	2 hour 4 hour 7 hour	$10 for 2 hour $25 for 4 hour $40 for 7 hour	Offered by Health Information Network. They will also travel to your facility.
Seattle	800-783-2437	2.5 hour 4 hour 7 hour	$30.41 for 2.5 hr $45.44 for 4 hr $53.21 for 7 hr	Offered by Health Impact.
Seattle	(206) 726-3534	2 hour 4 hour 7 hour	$21 for 2 hour $38 for 4 hour $65 for 7 hour	Offered by the American Red Cross.
Seattle	(206) 282-1288	7 hour	Call for info	Teen AIDS Prevention Education training for youth service providers, offered by YouthCare.
Spokane	(509) 326-3330 Ext. 210	2 hour 4 hour	$20 for 2 hour $30 for 4 hour	Offered by the American Red Cross.
Spokane	(509) 324-1542	7 hour	$50 for 7 hour	Offered by the Spokane Regional Health District.
Spokane	(509) 928-1588 Ext. 16	7 hour	$45 for 7 hour	Offered by Visions Community Resources.
Spokane	(509) 236-2430 Becky Nauditt	2 hour 4 hour	$18.00 $30.00	Community Health Access Services.
Tacoma (Pierce County)	(253) 841-3311 Barbara Miller	2 hour 4 hour 7 hour	$30 for 2 hour $40 for 4 hour $50 for 7 hour	Offered by C.P.R. Company.
Tacoma (Pierce County)	(253) 474-0600	2 hour 4 hour 7 hour	$15 for 2 hour $43 for 4 hour $55 for 7 hour	Offered by the American Red Cross.
Tacoma (Pierce County)	(253) 566-5020 Linda Finkas	7 hour 7 hour Independent Study	$40 for 7 hour $45 for video course	Offered by Tacoma Community College.
Vancouver	(360) 992-2939 Press Option One	2 hour 4 hour 7 hour	$30 for 2 hour $50 for 4 hour $60 for 7 hour	Offered by Clark College Continuing Education Program. Take home program that offers discounts for 2 or more students.
Walla Walla	(509) 527-4330	7 hour	$45 for 7 hour	Offered quarterly by Walla Walla Community College.
Whitman County (Colfax)	(509) 397-6280	4 hour Video Course 7 hour Video Course	$25 handling fee for tapes	Offered by the Whitman County Health Department.
Whitman County (Pullman)	(509) 332-6752	4 hour Video Course 7 hour Video Course	$25 handling fee for tapes	Offered by the Whitman County Health Department.
White Salmon (Klickitat County)	(509) 493-1101	2 hour, 4 hour, 7 hour and other First Aid classes	$25 for 2 hour $30 for 4 hour $50 for 7 hour	Offered by Skyline Hospital.
Yakima	(509) 248-3628	7 hour	$50 for 7 hour	Offered by Planned Parenthood of Central Washington.

HIV/AIDS TRAININGS TO MEET STATE LICENSING REQUIREMENTS, CONTINUED

Location	Phone Number	2, 4 or 7 hour Courses	Cost	Other Details
Yakima	(509) 457-1690	2 hour	$20 for 2 hour	Offered by the American Red Cross.
Yakima	(509) 853-2034 or 1-877-620-6202 http://www.fas-training.biz/	2 hour 4 hour 7 hour and other First Aid classes	$20 for 2 hour $35 for 4 hour $45 for 7 hour	Offered by First Aids & Safety Training.
Statewide	(206) 784-5655 http://www.healthinfonetwork.org/	HIV/AIDS 7-hour Video Course	$250	Offered by Health Information Network. Designed to assist health care facilities meet Washington State Licensing requirements.
Statewide	(206) 543-1047	HIV/AIDS Training Audiotape	$95 for 7.5 hours	Offered by U of W School of Nursing. Designed to assist health care facilities to meet WA State requirements.
Statewide	(425) 564-2012	HIV/AIDS Self Study Program $100 Refundable Deposit	$60 for 4 hr. * $80 for 7 hr. *includes mailing	Offered by Bellevue Com. College Continuing Nursing Education and Health Information Network.
Statewide	(206) 320-9822	2 hour 4 hour 7 hour	$30 for 2 hour $45 for 4 hour $65 for 7 hour	Offered by the Empowerment Institute. Course may be offered at your site.
Statewide Internet Classes	(707) 937-0518 www.nursingceu.com	2 hour 4 hour 7 hour	$20 for 2 hour $40 for 4 hour $70 for 7 hour	Washington State HIV/AIDS internet course offered by Wild Iris Medical Education.
Statewide Internet Classes	1-800-346-4915 www.classesonline4u.com	2 hour 4 hour 7 hour	$20 for 2 hour $40 for 4 hour $70 for 7 hour	Online course offered by Prevention MD.
Statewide Internet Classes	(509) 628-1317 Kathleen Hayes www.designerwebsitesolutions.com	2 hour 4 hour	$20 for 2 hour $40 for 4 hour	Online course offered by Designer Website Soltutions.

HIV Prevention Counseling and Testing Training Schedule for 2004-05

These one-, two- and three-day courses will assist health care providers and others develop necessary skills for providing pre- and post-test counseling for HIV testing, as required by Washington State law.

These courses are not intended for the general public.

Region	Trainer	Course Dates	
One (Spokane)	**Christopher Zilar** (509) 324-1542 or 1-800-456-3236 The cost varies according to length of class.	Dec. 7-9, 2004 Feb. 16-17, 2005 April 12-14, 2005 Jun. 15-16, 2005	(3 day) (2 day) (3 day) (2 day)
Two (Yakima)	**Deborah Severtson-Coffin** (509) 454-3322 The cost for the 2-day class is $85.	For 2005 course dates, please contact Deborah.	
Three (Everett)	**Eric Hatzenbuehler and Kevin Henderson** (425) 339-5251 The cost for the 2-day class is $75.	Nov. 8-10, 2004 For 2005 course dates, please contact Eric.	(3 day)
Four (Seattle)	**Robert Marks and Mark Alstead** (206) 296-4649 or e-mail to: diane.ferrero@metrokc.gov The cost for the 2-day class is $125. The cost fot the 3-day class is $175.	Nov. 2-4, 2004 Jan. 25-27, 2005 Feb. 22-23, 2005 May 10-12, 2005 Jun. 21-22	(3 day) (3 day) (2 day) (3 day) (2 day)
Five (Tacoma)	**Kim Ingram** and **Moni Muraki** (253) 798-2939 The cost varies according to length of class.	* Nov. 15, 2004 Feb. 23-25, 2005 May 26-27, 2005 Jun. 24, 2005 * In Olympia	(1 day) (3 day) (2 day) (1 day
Six (Vancouver)	**Beth McGinnis** (360) 397-8111 The cost for the 2-day class is $100.	*Nov. 3-5, 2004 Mar. 2-4, 2005 * In Olympia	(3 day) (3 day)

Calendar

November 1, 2004

Visit the **Day of the Dead exhibit at El Centro de la Raza** to view an altar honoring children and parents worldwide who have died of AIDS. Altars by 17 other organizations will also be displayed during the month. The exhibit is open Monday, Tuesday, Thursday & Friday 10:00 a.m. – 6:00 p.m. and Wednesday 10:00 a.m. – 8:00 p.m. throughout the month of November. El Centro de la Raza is located at 2524 16th Avenue South in Seattle.

November 9, 2004

The Governor's Advisory Council on HIV/AIDS (GACHA) meets from 9:00 a.m. to 3:00 p.m., November 9, at the Prime Hotel Seattle-Tacoma Airport (formerly Wyndham Gardens), 18118 International Blvd, Seattle, from 9:00 a.m. to 3:00 p.m. Visit **http://www.doh.wa.gov/cfh/HIV_AIDS/GACHA/Default.htm** for more information, or contact Lynn Johnigk at (360) 236-3444 or e-mail her at: **Lynn.Johnigk@doh.wa.gov**.

November 11, 2004

National Harm Reduction Conference's theme this year is "Working under Fire: Drug User Health and Justice." Held November 11-14, in New Orleans, the conference will host discussions on solutions to common concerns and issues, such as housing, medical care, the impact of drug use on families, the need for needle exchange programs, and new developments in the political and criminal justice arenas. The conference will bring together consumers, providers, and casemanagers. Visit: **http://www.harmreduction.org/conf2004/index.html** for more information.

November 15, 2004

The **Association of Nurses in AIDS Care** (ANAC) will hold its 17th Annual Conference November 15-18 in New Orleans. Among the issues that will be addressed are: treating women with HIV; HIV/HCV co-infection; long-term metabolic concerns of HAART and treatment options in patients with multiple ARV failure; appearance-related side effects and drug interactions; and HIV resistance testing. For more information on the conference go to: **http://www.anacnet.org/conferences/2004_ANAC_National_Conference.htm.**

November 18, 2004

The Centers for Disease Control and Prevention (CDC) will broadcast a two-hour forum, entitled **"Rapid Testing: Advances for HIV Prevention,"** on November 18, 2004, from 1:00 p.m. to 3:00 p.m. EST. This simultaneous, live satellite broadcast and webcast will provide information regarding the availability and administration of rapid tests for HIV. Implementation considerations, including: providing counseling, testing women in labor, obtaining CLIA certification, establishing a quality assurance program and training health care providers will be explored as well. The forum highlights several public and private organizations, including clinical settings. In addition, a panel will answer questions faxed in from viewers. Community organizations, including AIDS services organizations; public and private laboratories that administer rapid testing for HIV; public health settings; hospital departments such as emergency rooms and labor and delivery units; and health care centers are recommended to participate. For additional information, please call the National Prevention Information Network at (800) 458-5231, or visit **http://www.cdcnpin-broadcast.org/.**

November 25, 2004

16 Days of Activism Against Gender Violence Campaign is an international campaign originating from the first Women's Global Leadership Institute sponsored by the Center for Women's Global Leadership in 1991. Participants chose the dates, November 25, International Day Against Violence Against Women and December 10, International Human Rights Day, in order to symbolically link violence against women and human rights and to emphasize that such violence is a violation of human rights. This 16-day period also highlights other significant dates including December 1, which is World AIDS Day, and December 6, which marks the Anniversary of the Montreal Massacre. Visit: http://www.cwgl.rutgers.edu/16days/about.html

December 10, 2004

The Governor's Advisory Council on HIV/AIDS (GACHA) and the **AIDSNET Council** hold a joint meeting from 9:00 a.m. to 1:00 p.m., December 10, at the Red Lion Hotel, 18220 International Blvd, Seattle. A regular business meeting for each Council will be held separately from 1:15 p.m. to 3:00 p.m. Visit **http://www.doh.wa.gov/cfh/HIV_AIDS/GACHA/Default.htm** for more information, or contact Lynn Johnigk at (360) 236-3444 or e-mail her at: **Lynn.Johnigk@doh.wa.gov**.

Save the Date

April 10, 2005

The next **amfAR National HIV/AIDS Update Conference** will take place in Oakland, California, **Sunday, April 10, through Wednesday, April 13, 2005.** Clinicians and caregivers will be joined by people living with HIV/AIDS for a comprehensive look at all aspects of the epidemic, including the latest practical information on AIDS prevention, treatment and care, and key policy questions facing people living with HIV/AIDS in America's cities and all over the world. For more information, go to: **www.amfar.org/nauc.**

April 21, 2005

North American Syringe Exchange Convention (NASEC) presents an opportunity for those interested in syringe exchange and disease prevention to gather, share information and build a network. Session topics include: how to start a syringe exchange program; harm reduction and various approaches to outreach; HIV/Hepatitis prevention; and, latest needle exchange research data. The convention will be held at the Sheraton Tacoma Hotel, 1320 Broadway Plaza Tacoma, Washington. For more information, telephone North American Syringe Exchange Network at (253) 272-4857 or visit www.nasen.org.

July 12, 2005

The 2005 National HIV Prevention Conference, convened by CDC and other government and non-government agencies, is set for the Hyatt Regency Atlanta, in Atlanta, Georgia, from **July 12-15, 2005**. The National HIV Prevention Conference, held every two years, is noted for its sole focus on HIV prevention, bringing together prevention programs and science. Past attendees have included local, regional, and national decision makers; researchers; policy makers; community leaders; and practitioners working to prevent the spread of HIV/AIDS.

National HIV Prevention Conferences offer opportunities to: share effective prevention approaches and research findings among government, community, and academic partners in HIV prevention; and, strengthen collaborations between program practitioners and researchers in areas including behavioral interventions, vaccine development, monitoring the epidemic, developing rapid and reliable tests for HIV diagnosis, and improving access to early treatment for HIV. For more information, visit http://www.cdc.gov/hiv/subscribe.htm.

Volunteer Opportunities

November 8, 2004

Holiday Wishes for Children Affected by HIV & AIDS

Each year the children in the Puget Sound counties affected by HIV and AIDS make a wish list of wants and needs for the holidays. Donors are needed to fulfill these wishes for children who might not receive any other gifts during this season. Wish lists will be distributed on November 8th and gifts gathered by December 16th. For more information please contact Aaron Holsworth at **Rise n' Shine,** (206) 628-8949 ext. 228 or visit **www.risenshine.org.**

November 13, 2004

Volunteers Needed to Support Children Affected by HIV & AIDS

Rise n' Shine volunteers provide one-on-one mentor relationships, peer support groups, and summer camp to children and teens affected by HIV and AIDS living in King, Pierce, Snohomish and other Puget Sound counties. They will be holding a new volunteer training the weekend of November 13th and 14th. For a volunteer application and information please call Danica Smith at (206) 628-8949 ext. 210, e-mail Danica@risenshine.org or visit www.risenshine.org.

Shanti Volunteer Training: Shanti volunteers make a difference in the community by providing caring support for people affected by HIV/AIDS, cancer, or other life-threatening illnesses. By listening without judgment and engaging in a comforting one-to-one relationship, our volunteers provide a safe space for people to talk about dealing with illness. The Shanti training and volunteer experience has been described as lifechanging for many volunteers. For more information, please call 206-324-1520 x3 or email www.seattleshanti.org.

World AIDS Day 2004: Equality for Women Helps Fight AIDS

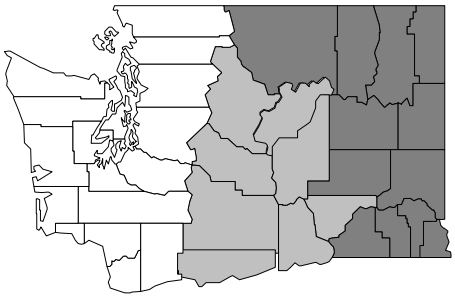
The World AIDS Campaign theme for 2004 is Women, Girls, HIV and AIDS. According to UNAIDS, the rate of HIV infection among young people worldwide is growing rapidly- 67% of newly infected individuals in the developing world are young people between ages 15 and 24 years old. 64% of these newly infected people are young women and children. Studies show that young women and girls can be 2.5 times more likely to be HIV-infected as their male counterparts. Women are twice as likely as men to contract HIV from a single act of unprotected sex, but they remain dependent on male cooperation to protect them from HIV infection. AIDS intensifies the feminization of poverty, particularly in hard-hit countries, and disempowers women. This gender inequality fuels the AIDS epidemic. Copies of World AIDS Day posters and other

campaign support materials are now online at: **http://www.unaids.org/wac2004/index_en.htm.** Campaign posters end with the strong message: "Equality for women helps fight AIDS". The global epidemiological update will be launched to the media in the run-up to World AIDS Day, this year on November 23rd, 2004. It will include a section highlighting the impact of HIV and AIDS on women and girls.

Saving Lives, Changing Lives: World AIDS Day Benefit Luncheon

Wednesday, December 1st, 11:30 - 1:30 pm at Washington State Convention and Visitors Center. This benefit Luncheon for Multifaith Works will showcase the mission and service of Multifaith Works to people living with AIDS, MS or other life threatening illnesses over the last 16 years. Guest speaker will be Dr. Stephen Jones, Seattle First Baptist Church. For information and registration, please contact Gary at 206.324.1520 x229 or gary@multifaith.org.

Regions 1 & 2



Region One (dark area) includes Adams, Asotin, Columbia, Ferry, Garfield, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, Walla Walla and Whitman Counties. The Region One AIDSNET Office is in Spokane and the Coordinator is Barry Hilt at (509) 324-1551.

Region Two (gray area) includes Benton, Chelan, Douglas, Franklin, Grant, Kittitas, Klickitat and Yakima Counties. The Region Two AIDSNET office is in Yakima and the Coordinator is Wendy Doescher at (509) 249-6503.

Transitions

The **Spokane Regional Health District (SRHD) HIV/ AIDS and Reproductive Health Program** says goodbye to both **Stacey Ward** and **Cindy Fine**, who have recently moved on to other opportunities. Both Stacey and Cindy brought tremendous dedication and hard work to the Teen Pregnancy Prevention and Reproductive Health programs at the Spokane Regional Health District. They will be greatly missed by clients and staff. Also, the HIV/AIDS and Reproductive Health Program welcomes Ellen Kirschbaum who will be serving as the new Unintended Pregnancy Prevention Coordinator and Sally Sabin who has also recently joined the staff as the Teen Pregnancy Prevention Coordinator.

Announcements

A new community based organization is solidifying its roots in Region 1 **Community Health Access Services of Eastern Washington** was established as an offshoot of the **ROPED Program** (Regional Outreach & Prevention Education Development). ROPED was initially housed in the Spokane Regional Health District's HIV/AIDS Program, then temporarily at the Coalition of Responsible Disabled. Since January 1, 2004, Community Health Access Services is the new CBO and final home for ROPED.

ROPED continues to focus HIV prevention efforts primarily on **American Indians residing in urban and rural geographical areas.** ROPED has succeeded in increasing outreach services and access for at-risk American Indians – connecting them with program interventions and HIV counseling and testing services. This could not have been achieved without strong collaborative relationships, and ROPED appreciates the support and guidance of its community partners. ROPED will continue to strengthen relationships with tribal and community organizations to further enhance access to services for high-risk American Indians as well as African Americans.

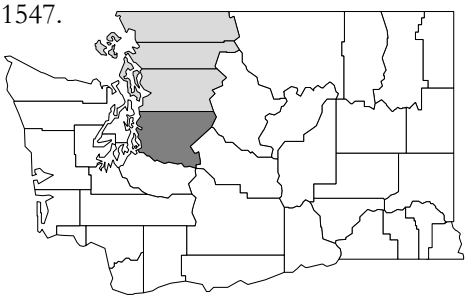
Community Health Access Services also supports a **HIV youth prevention program, YACK** (Youth Advocates Cultivating Knowledge). YACK assists schools in meeting HIV curriculum requirements utilizing a unique, comprehensive and interactive approach in teaching HIV prevention education. Students are actively engaged in the learning process instilling eagerness to learn and participate. YACK ensures age appropriateness and curriculum flexibility, as well as being respectful to the values of individual schools and communities.

For more information on ROPED or YACK, or other programs and services provided by Community Health Access Services, contact Becky Nauditt at 509-236-2430 or bnauditt@icehouse.net.

The Ryan White Consortium in **Spokane** now meets bi-monthly, resulting in increased consumer participation. The Consortium continues to address needs expressed by

consumers, particularly those needs that did not receive funding in the current Ryan White Cycle. For further information please contact Ann Willis at (509) 324-3606.

The **SRHD HIV/AIDS and Reproductive Health** programs will be completing a **yearlong project designed to increase MSM access to STD testing.** The effort originated in response to the increases in new STD infections recorded in Western Washington, and the possible increase in new STD infections occurring in the Eastern part of the state. Staff members in the Clinic, the HIV/AIDS and Reproductive Health Program, and Assessment worked together to conduct focus groups and coordinate client recommendations for clinic improvements as well as to design advertising messages specifically to encourage men who have sex with men to seek STD and HIV testing. The project concludes December 2004 with a targeted ad campaign in the Stonewall and the Inlander. For more information please contact Lisa St. John at (509) 324-1547.



Regions 3 & 4

Region 3 (gray area) includes Island, San Juan, Skagit, Snohomish and Whatcom Counties. The Region 3 AIDSNET office is in Everett and the Coordinator is Alex Whitehouse at (425) 339-5211.

Region 4 (dark area) is King County. The Region 4 AIDSNET office is in Seattle and the Coordinator is Barbara Gamble, who can be reached at (206) 205-0937.

Transitions

Evergreen AIDS Foundation bid a fond farewell to Case Manager and Women's Program Coordinator, **Janet Ballard** at the end of June. Janet's tireless efforts in advocating for women and families infected and affected by HIV are greatly appreciated, and she is wished satisfaction and success in her new position as Case Manager for Snohomish Health District. Evergreen staff is proud of Janet, and completely confident in her ability and talent- she is wished the best of luck in realizing her dreams.

Letting go with one hand, and taking hold with the other, EAF is pleased to welcome new Case Manager and Women's Program Coordinator, **Wendy Weitz.** She is a long time resident of Whatcom County, and a professional in the field of human services for more than nine years, with a strong background in mental health issues. Since her arrival at the beginning of July, her sense of focus and dedication have shown Ms. Weitz to be an excellent addition to the team; there is no doubt that she will accomplish much for her clients in all future efforts.

The AIDS Outreach Project & Snohomish County's Clean Needle Exchange Program have had some major changes in the last few months. Effective June 2, 2004, **Art Israel** resigned his position as a CHOW with the program. Art held this position for over 7 years and he is wished well in his future travels.

On July 1, 2004, **Trina Potter** was welcomed as the new Community Health Outreach Worker (CHOW). Trina has been a volunteer for the program in the past and it is wonderful to have her back, this time as a full time employee. Trina comes with many skills and gifts, and the program is very lucky to have her on staff. Welcome Trina!

Also, kudos to **Cheri Speelman** who just celebrated her 8-years anniversary on August 26, 2004 as long-time director and fearless leader of the program. Congratulations Cheri!

ANNOUNCEMENTS

HIV/AIDS Health Educator **Brenda L. Newell of Snohomish Health District** recently received awards for her work with youth in Snohomish County. Washington State Department of Social and Health Services selected Ms. Newell for its **2003 Diversity Award,** citing her dedication to providing a supervised and safe environment, reliable health information, and counseling to gay, lesbian, bisexual or transgender teens. Ms. Newell also received the **Civic Award** from the Imperial Sovereign Court of the Empire of Snow and Ice, in recognition of her educational outreach work to the gay community in Snohomish County.

Since joining the Health District in 2000, Brenda has worked to prevent the spread of HIV/AIDS among high-risk populations and youth. In 2002 she was named **Educator of the Year** by a multi-county HIV/AIDS network for her ability to create effective working partnerships among community organizations. "Education that results in behavioral changes is our most effective weapon in the fight against AIDS," said M. Ward Hinds, MD, MPH, health officer for Snohomish Health District, "and Brenda Newell is a one-woman arsenal. She delivers clear, strong messages about preventing HIV/AIDS and other sexually transmitted diseases, and she does it because she wants people to make healthy choices," he said. Newell, a licensed clinical social worker, earned a Master of Social Work degree from University of Washington. Prior to her position at Snohomish Health District, Newell worked extensively in counseling and crisis intervention for abused women and children. Her volunteer work includes community education about domestic violence, and participation in the Safe Schools Coalition.

"Snohomish Health District attracts staff who are both highly skilled and dedicated to the mission of public health. Brenda Newell exemplifies this combination," said Dr. Hinds.

Evergreen AIDS Foundation (EAF), in Bellingham, has had a productive spring and summer this year. Besides the everyday workings of a non-profit organization, the agency has facilitated several outreach events at the local college, mall and at a festival. There have been four recent client forums that focused on, respectively: Hepatitis C, nutritious and economical cooking, home-based fitness, and diabetes nutrition. EAF hosted a lecture on the AIDS Quilt, and hosted a gathering at Sean Humphrey House to recognize that special connection and the folks who make it happen. Two board members retired and were honored one evening. Also, a case manager started a new positive women's support group.

One substantial event in April was called ***"Queer Plan for the Straight Man,"*** based on the popular television show. A local "fab five" made over a local contractor, which brought welcome and positive publicity to EAF, as well as to the nature of its work. In May, Development Director, Marcy Mjelde presented the first-ever ***"Garden Path of Hope"*** auction and luncheon at Lairmont Manor, considered a popular and economic success due to the immense generosity of EAF's patrons.

Additional adventures included: a **Phone-A-Thon, and a Fourth of July Fireworks Cruise** on Bellingham Bay. Also, the popular Australian band **Fruit** performed a July benefit concert. July also included The **Annual Client Picnic** with family and friends at Lake Padden. In August, volunteers manned the **"free coffee" fundraiser** at the south bound I-5 rest area and at the north bound stop (Bow Hill) in October.

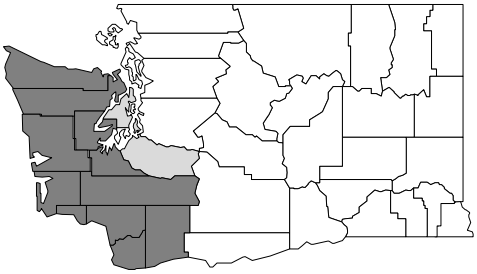
Fall activities include fundraisers such as **"Dine Out for EAF"** in October and **Northwest Artists United Against AIDS** benefit auction in September. Visit **www.evergreenaids.org** to view a sampling of some of the auction pieces.

Evergreen AIDS Foundation is pleased to announce that production on the video titled **"The Face of AIDS in Whatcom County"** continues on schedule. The documentary, approximately forty-five minutes long, will be aired on local cable, shown at the Pickford Cinema, and be presented at regional campuses as a tool to furthering understanding and awareness. The lives portrayed here are what hearten and motivate the staff to continue on in their responsibilities and obligations to EAF's amazing clients.

Rise n' Shine, a local non- profit that provides support for children affected by HIV & AIDS, will be moving after spending 15 years in a downtown Seattle space donated by the Bank of America. The move will take place over the December holidays. The new address will be printed in the next issue of Washington State Responds Newsletter. If you have any questions please call (206) 628-8949 or visit **www.risenshine.org.**

Health Information Network continues to provide live childcare HIV trainings as well as the 4- and 7-hour HIV trainings for health care providers. The updated video kit is now completed and 100 facilities around Washington State are using it. Seattle Community College's TV Division will use the updated HIV/AIDS content for their online educational tool, Planet. Expanded educational efforts using streaming video should be operational later this fall.

Regions 5 & 6



Region 5 (gray area) includes Kitsap and Pierce Counties. The Region 5 AIDSNET office is in Tacoma and the Coordinator is Mary Saffold at (253) 798-4791.

Region 6 (dark area) includes Clallam, Clark, Cowlitz, Grays Harbor, Jefferson, Lewis, Mason, Pacific, Skamania, Thurston and Wahkiakum Counties. The Region 6 AIDSNET office is in Vancouver and the coordinator is David Heal at (360) 397-8086.

Transitions

Kitsap County Health District welcomes **Lisa Linden** as the new level II Case Manager. Lisa has her M.A. degree in Mental Health, and comes to Kitsap with a wealth of experience acquired during her life as a Los Angeles native. She is an artist and serious traveler as well.

Dr. Justin Denny has been selected and appointed to be the **Health Officer for Clark and Skamania Counties.** Dr. Denny has his Master of Public Health degree from Oregon Health Sciences University, where he completed both a Preventive Medicine Residency program and a Family Medicine Residency program. He received his Doctorate of Medicine from Eastern Virginia Medical School in Norfolk, VA.

Currently Dr. Denny serves as Health Officer for the Wasco/Sherman Health Department in The Dalles, Oregon and for Columbia County Health Authority in St. Helens, Oregon. In addition, he works at Portland State University where he provides acute and chronic medical management for university students, teaches a course on global health and speaks on smoking cessation. As part of his work there, he received grant funding to reduce the frequency of binge drinking among student athletes. Dr. Denny is well prepared to lead on the infectious disease control and prevention work and in emergency

Announcements

The HIV/AIDS Program at **Kitsap County Health District** offers **Rapid Testing** by appointment only. Rapid Testing is proving to be popular; the favorable response has increased testing numbers by 15-20%.

STATE PLANNING GROUP

For specific meeting locations and topics, contact Harla Eichenberger at: (360) 236-3424 or visit: **http://www.doh.wa.gov/cfh/HIV_AIDS/Prev_Edu/HIV_Community_Planning.htm**.

COMMUNITY PLANNING

The six **AIDSNET Regions** continue to coordinate the local planning process through meetings of the Regional Planning Groups (RPGs). This process absolutely requires input and participation from members of the community infected and affected by this epidemic. Are you willing to become one of the voices that support effective prevention efforts? If so, please contact your local Regional Coordinator or DOH contact in the list below, for more information.

Barry Hilt - Region 1 AIDSNET (Spokane) – (509) 324-1551

Wendy Doescher – Region 2 AIDSNET (Yakima) – (509) 249-6503

Alex Whitehouse – Region 3 AIDSNET (Everett) – (425) 339-5211

Karen Hartfield – Region 4 AIDSNET (Seattle) – (206) 296-4649

Mary Saffold – Region 5 AIDSNET (Tacoma) – (253) 798-4791

David Heal – Region 6 AIDSNET (Vancouver) – (360) 397-8086

Brown McDonald – State Planning Group (SPG) – (360) 236-3421

HIV Prevention Focus

Interventions that Work

By Frank E. Hayes; DOH HIV Prevention and Education Services

During the first two decades of HIV prevention, we have learned many valuable lessons concerning the processes involved in assisting individuals to change risky behavior, and what type(s) of interventions work best; and, we have identified many interventions (through evaluation) shown to be effective in changing behaviors. I ask you, "*Have we been paying attention, learning from successful programs, and making changes in our prevention efforts accordingly? Or have we chosen not to pay attention and conduct prevention interventions in the same manner, regardless of the findings?"* We need to ask ourselves these tough and important questions when we are preparing to conduct HIV prevention interventions.

There are two practices that should be at the top of our "things to remember" list. The ***first*** practice is working with the intended population during the formative evaluation stage. Collaboration with the primary population when formulating or selecting an intervention is imperative and may result in an efficacious use of limited resources (time, money and personnel). We may think we know what will work in reaching a particular population and assisting them in changing their risky behavior, but is it what **they** feel is needed, what **they** believe will work in assisting **them** to change their risky behavior? We need to get the "buy in" from **them** for the proposed intervention. Think of the last time there was a change in your professional or personal life. If your opinion was actively sought before a decision was made, acceptance of any change was much easier. The ***second*** practice is conducting a pilot of the intervention with a small segment of the intended population. Even the best plans may have rough spots when an intervention is implemented. Pilot testing allows an agency the opportunity to evaluate the intervention in a realistic setting. This step is important because it assists an agency to identify and make necessary changes prior to conducting the intervention for the intended population. Do these two steps guarantee the intervention will be successful? No they don't, they start an agency on the correct path to reach the desired population with an intervention that meets their needs.

The next two concepts are not specific to HIV prevention, but apply to many areas of our daily life; we should be very cognizant of them in our prevention efforts. They are: 1) investigating and knowing what is not working; and, 2) transforming a negative aspect into something positive, rather than merely dwelling on the problem. As an illustration of the first point: I participated in a type of focus group in which the facilitator wanted to talk about what was working well, but did not appear to be interested in hearing what was not working well. It is extremely important to investigate and know what is not working; this will allow you to look for ways to improve your intervention and turn those non-working aspects into fully viable functioning sections. Knowing what is not working is an important part of evaluating prevention efforts.

It is also important regarding supporting segments of HIV prevention activities. As an example, SHARE (Statewide HIV Activity Reporting and Evaluation) system is the current non-client level data collection system that provides answers to process monitoring questions. Using the system correctly and providing the required information allows agencies a mechanism to review the HIV intervention delivery and monitor the parts of the process working well and those needing attention. It also allows agencies to identify the process related service delivery activities they were not capturing. Over the life of SHARE, we noted shortcomings and changed the system to address those shortcomings. As I am sure some of you

know, CDC is working on a client level data collection system that will provide additional information about interventions and those who access services. The system being piloted will address shortcomings that SHARE does not address.

The second concept, transforming a negative aspect into something positve, rather than merely dwelling on the problem, was illustrated during a Department of Health meeting. One of the presenters talked about overcoming different situations after she had been told, "You can't do that." She was able to get past the obstacles placed in her path because she turned "can't" into "can". It is easy to get stuck on barriers that prevent us from providing services rather than looking at what can be accomplished. Dwelling on non-working aspects will not solve a difficult situation; it will just raise frustration levels. You may have heard colleagues say: "*We can't do that because we don't have the money." "We can't reach the population because we don't know where they hang out." "There isn't an evaluated intervention available to reach our population."* One or all of those comments may be correct, but turning the negative aspect into something positive is essential. If there are not enough funds available to conduct the desired intervention, investigate what intervention can be accomplished with the dollars available. Another possible solution is to investigate where to obtain additional funding. Reaching populations in certain areas is more of a challenge than others. Review and think about: (1) location where workers try to reach the desired population- conducted activities may not be in the right location; (2) is there a big need for prevention services to the population you are trying to reach; and (3) understand reaching some populations takes substantial time and patience. These concerns are the same in urban and rural areas. If there isn't an intervention that has been evaluated and tested with your specific population or an area similar to yours, review the interventions available to see if your population fits into one of the available interventions. After collaborating with the population and conducting a pilot, you may find an intervention can be adapted or tailored to meet your populations' needs.

Educators, outreach workers, professional and paraprofessionals in HIV prevention are not involved because of financial gain; they are involved because of their desire and compassion to help those in need. The services provided are necessary and greatly appreciated by those reached through staff's tireless efforts. Many of the people reached may not be in the main stream of society and would not receive services if it weren't for the commitment and awe-inspiring efforts put forth by prevention staff. It is important to keep our eyes open to ensure the services provided and HIV prevention interventions conducted remain current. Change and the need to stay abreast with current trends in HIV prevention are constant processes. This reminds me of something I have heard many times, "If we do the same old thing, in the same old way, we will get the same old thing, we always got." Let's not forget the importance of: involving your desired population in all aspects of your intervention, remaining positive, being open to change and new ideas, and not getting bitten by the "can't" bug.

Intervention in the Spotlight

Intervention Type: Group-level Intervention

Risk Transmission Category: Heterosexual

Behavior Placing Them at Risk: Sexually active African American adolescent girls

Setting: Family Medicine Clinic

Study Title: "*Efficacy of an HIV Prevention Intervention for African American Girls. A Randomized Controlled Trial*" Ralph J. DiClemente, PhD, Gina A. Wingood, ScD, MPH, Kathy F. Harrington, MPH, MAEd, et al. The Journal of the American Medical Association, July 14, 2004-Vol 292, No.2: 171-179.

Article Description:

The researchers stated adolescents were acknowledged as a population at risk for HIV; among those adolescents, African American girls were the subgroup at particularly high risk for HIV. Interventions specifically designed for this population had not been successful in reducing their HIV risky behavior. There is a clear, cogent, and compelling urgency to develop and implement *effective* prevention interventions in response to the growing HIV epidemic among this population. This need is not specific to African American adolescent females; it is imperative to conduct *effective* interventions for each and every population we try to reach. Furthermore, the researchers reviewed a recent meta-analysis and other literature that indicated theoretically derived and empirically based HIV interventions can successfully promote adolescents to adopt protective sexual behaviors.

The objective of the study was to evaluate the efficacy of an intervention to reduce sexual risk behavior, sexually transmitted diseases (STDs) and pregnancy, and enhance mediators of HIV prevention behaviors. Two related scientifically based ideas were the complimentary theoretical frameworks that guided the design and implementation of this HIV prevention intervention. *The Social Cognitive Theory* – this theory maintains skills involved in new behaviors are learned through either direct experience or by modeling the behaviors of others. The two key behavioral determinants are outcome expectations (the extent to which a person values expected outcomes) and self-efficacy (belief that one is capable of performing a particular behavior). *The Theory of Gender and Power* – this theory maintains sexual division of labor, sexual division of power, and the structure of emotional energy concentration characterize the gender relationship between men and women.

This theory-based intervention was conducted in Alabama between 1995 and 2002. From December 1996 through April 1999, recruiters screened 1,130 African American adolescent girls who sought medical services at one of four community health service agencies. Of the girls interviewed, there were 522 who met the eligibility criteria and completed the baseline assessment. The criteria were: being African American, female, 14-18 years old; having vaginal intercourse in the preceding 6 months; and, providing written informed consent. The Institutional Review Board at the University of Alabama at Birmingham waived parental consent. Each girl was compensated with $25 for travel and child care to attend each intervention session and complete the three assessments. The research team collaborated with African American girls in the community to develop the study conditions. The fact that this occurred should not be a new concept to you; the importance of including the priority population in the design, implementation, and evaluation of an intervention is crucial. Based on

feedback and consultation with the young ladies, the design of the HIV prevention consisted of four interactive group sessions conducted on consecutive Saturdays. Each four-hour session was conducted in a family medicine clinic. Prior to the implementation of the main trial, the interventions were conducted under field conditions with adolescents from the study population.

The study was a randomized control trial. Prior to enrollment, an investigator used a random-numbers table to generate the allocation sequence. Upon completion of the baseline assessment, each participant received an envelope containing her group assignment. They were either assigned to the general health promotion (control group) or the intervention group. Each intervention group session was conducted by a trained African American female health educator and two African American female peers. Topics consisted of the following: *session 1* – emphasized ethnic and gender pride; *session 2* - enhanced awareness of HIV risk reduction strategies; *session 3* – enhanced confidence in initiating safer sex conversations through role play and cognitive rehearsal; and *session 4* - emphasized the importance of healthy relationships. To reduce the likelihood of the HIV prevention intervention's positive results being attributed to group interaction or Hawthorne effects, those young ladies assigned to the general health promotion (control group) also received four 4-hour interactive sessions. Two sessions emphasized nutrition and two sessions emphasized exercise. As a reminder, the Hawthorne effect is basically an intervention having the desired outcome, but not for the reason expected; i.e. the positive outcome turns out to have no basis on the intervention's theoretical motivation, but is due to the effect of the participants knowing they are participating in a study that has outcome measures. This phenomena was first noticed in the Hawthorne works of the Western Electric Company in Chicago.

As stated earlier, the participants completed three assessments. The first (baseline) assessment was completed prior to entry into the intervention, the second assessment occurred six months after completing the intervention, and the final assessment occurred 12 months after completion of the intervention. All participants (control and intervention group) completed each assessment. The same data was collected during each assessment and consisted of: a self administered questionnaire assessing sociodemographics and psychological mediators of HIV prevention behaviors; assessment of sexual behavior by a trained African American female interviewer; the interviewer assessing the participant's ability to correctly apply a condom; and finally, the participants provided 2 self-collected vaginal swabs for STD analysis. There were also seven additional outcome measures discussed during the assessment.

To ensure quality assurance, a trained moderator attended all study sessions to rate the fidelity of the intervention. Nearly 98% of the activities in each group were implemented with fidelity. Participants' completion rate was 95.2% in the intervention group and 94.5% in the control group. Effects of the intervention revealed HIV intervention participants were more likely than the general health promotion group to report: (1) using condoms consistently in the 30 days preceding the 6 and 12 month assessment; (2) using condoms consistently during the 6 months prior to the 6 and 12 month assessment; (3) a significantly higher percentage of condom-protected sex acts in the 30 days and in the 6 months preceding the 6 and 12 month assessment; (4) significantly fewer unprotected vaginal intercourse episodes in the 30 days and in the 6 months preceding the 6 and 12 month assessments; and (5) a higher frequency of putting condoms on their partner at the 6 and 12 month assessments. To enhance self-reporting sexual behaviors, participants were asked to report behaviors over a relatively brief period and were provided calendars specifying the reporting intervals of interest. The overall conclusion: interventions for African American adolescent girls that are gender appropriate and culturally harmonious can enhance HIV prevention behavior skills, and may reduce pregnancy and other STDs. Two limitations of the interventions were noted: findings may not be applicable to African American adolescent girls with different sociodemograhic characteristics and methodological concern regarding the reliability of self-reported outcome measures.

If you are with an agency whose priority population is African American adolescent females you may want to consider this intervention. Using the feedback received from a community needs assessment and this short synopsis of the intervention, this information will assist you in determining if your population fits into this intervention. If your prioritized population fits this intervention, the intervention may be replicated. If there are differences, adaptation of the intervention may be necessary to meet your population's needs. To maintain fidelity and ensure effectiveness, you **must** remember to maintain the core elements. After reviewing the article, it is my opinion there are three-core elements:

1) Gender and culturally specific;

2) Four four-hour group sessions consisting of

a. Ethnic and gender pride,

b. HIV risk reduction strategies,

c. Enhancement of confidence (safe sex negotiating, conversations and unsafe sex refusal skills), and

d. Importance of healthy relationships

3. Trained African American female health educator and female peer facilitators.

There were two other extremely important actions which occurred prior to implementation of the intervention that are not one of the core elements and yet really are a "must". Those two elements are: (1) working with the primary population to assist in formulating the intervention, and (2) conducting a pilot of the intervention with a small segment of the desired population.

The contact for the original article is: Ralph J. DiClemente, PhD, Rollins School of Public Health, Department of Behavioral Sciences and Health Education, 1518 Clifton Rd NE, Room 554, Atlanta, GA 30322. Email address is: **mailto:rdiclem@sph.emory.edu.** If you have questions or comments for me, I may be contacted by telephone at (360) 236-3486 or via email at **frank.hayes@doh.wa.gov.**

The STD Focus

BY BONNIE NICKLE; DOH STD EDUCATIONAL RESOURCE COORDINATOR

STD 101 for Outreach Workers

Herpes: We Interview a Nurse Practitioner

Washington State Responds interviewed Terri Warren, a Nurse Practitioner who has had her own clinic specializing in STDs, the Westover Heights Clinic in Portland, Oregon, since 1982. The Westover Heights Clinic specializes in general health care along with STD services, counseling and STD research.

1. Terri, many of our readers deal with those at highest risk for HIV infection. It's hard enough to reach clients on that topic, never mind STDs. Should they even try to discuss STDs like herpes type 2 (HSV-2) ?

I recently teamed with Anna Wald, MD, MPH who is the medical director of the virology research clinic at the University of Washington for a presentation that included this issue. She said that the main thing to remember about this complex problem is that a person who has HSV-2 and is then exposed to HIV is twice as likely to become HIV-infected. So, yes, keep trying.

2. Some outreach workers find it difficult to have to explain HSV asymptomatic infection. The clients "get it" when it comes to HIV, but STDs have not had as much publicity on this issue. Why do so many people with HSV-2 not know they are infected?

Most HSV infections are subtle, not dramatic. There are what we call "look-alike" symptoms - - a red area, an itchy area. People are looking for classic, textbook symptoms of a true primary infection and 90% of those infected simply won't have them.

Also, outbreaks can appear in areas that are not strictly genital. I call this the "boxer shorts" zone. If you remember that herpes travels out from the spinal cord on the ganglia (nerve system) to the area where the virus first entered the body and that people have all kinds of skin-to-skin contact that is not strictly genital, you'll understand that outbreaks can show up in the anal area, at the base of the spine, the buttocks, the thigh and the lower abdomen. Just picture those shorts….

People can also assume or be told that recurring outbreaks are shingles, or herpes zoster. If something is recurring, think herpes simples, not zoster. Shingles in a healthy adult is not a recurring disease except in about 3% of all cases. Get tested.

3. What other mistaken ideas do people have about symptoms? What do they think they have?

Men say they have folliculitis, jock itch, "got caught in the zipper of my jeans," hemorrhoids, condom allergy, friction burns, poison ivy/oak, irritation from tight athletic gear or jeans, bike seat irritation, too much masturbation, and bites – human and insect.

Women name yeast infections, vaginal infections, urinary tract infections, hemorrhoids, and heat rash.

Itching is the most common complaint. Of course, both men and women may have these conditions (listed above) and they should be evaluated. But, if it is something that recurs and gets better in 5 days, think herpes and get the right test done.

People also mention allergies to condoms, elastic, pantyhose, spermicides or sperm and "my partner." Irritation from shaving, douching, and intercourse are on the lists as well.

4. Many women self treat for what they believe are yeast infections. What's the interaction here, if any?

Well, they go to the store and get over-the-counter medication for yeast. They take it for 5 days, their symptoms go away, and they think this is just the perfect cure when they have itching. In fact, this may be herpes and they need to be tested.

5. Outreach workers have many clients for whom the cost of serological (blood) testing for herpes is a big issue. If we did not have to consider cost, who should consider testing?

A partial list would include those with past partners who now worry if they are infected but are without symptoms, someone who was diagnosed by visual exam alone and does not believe they are really infected or who wants viral typing, someone who has repeated outbreaks but negative culture tests, someone who has repeated urinary tract infections but the tests never show bacteria, anyone who wants full screening for STDs, and pregnant women who believe they do not have herpes, but whose partner thinks he does have this infection.

In general, the risk of transmission decreases if people know they are infected. They can abstain during outbreaks and tell their partners so informed choices can be made. Using condoms, though not 100% effective is a part of reducing transmission, especially transmission to women. Patients can be treated (but nor cured) so that they might have fewer outbreaks, less viral shedding and less chance of transmission.

Ms. Warren's web site at **http://www.westoverheights.com/** includes clinic service information, phone numbers and generous free access to a forty-page herpes handbook.

Selected Readings

How to Read the References

Author(s), "Title," *Journal Name*, Date or Year; Volume (Number): Pages.

Key:

* Popular Reading

** Moderate Difficulty; Some Understanding Of

*** Medical Background Needed

**** Technical Reading.

If you cannot access library services, please contact Bonnie Nickle at (360) 236-3460 for single copies of these articles.

** Moss N.J., Gallaread A., Siller J. and Klausner J.D. "Street Medicine: Collaborating With a Faith-Based Organization to Screen At-Risk Youths for Sexually Transmitted Diseases." *American Journal of Public Health.* July 2004:94(7):1081-1084. Includes good information on costs for this outreach effort.

*** Lukehart S.A., Godornes C., Molini G.J. and others. "Macrolide Resistance in *Treponema pallidum* in the United States and Ireland." *New England Journal of Medicine.* July 8, 2004;351(2):154-158. Azithromycin therapy report.

**** Ashley-Morrow R.A., Freidrich D., Krantz E. and Wald A. "Development and Use of a Type-Specific Antibody Avidity Test Based on Herpes Simplex Type 2 Glycoprotein G." *Sexually Transmitted Diseases.* August 2004;31(8):508-515.

*** Wald A., Erricsson M., Krantz E. and others. "Oral Shedding of Herpes Simplex Virus Type 2." *Sexually Transmitted Infections.* August 2004;80(4):272-276. The authors state that oral shedding of HSV 2 is infrequent and usually occurs without lesions.

** Maw R. "Critical Appraisal of Commonly Used Treatment for Genital Warts." *International Journal of STD and AIDS.* June 2004;15(6):357-364. Literature review. Includes chart of clearance and recurrence rates for various treatments.

*** Nsuami M., Cammarate C.L., Brooks B.N. and others. " Chlamydia and Gonorrhea Co-occurrence in a High School Population." *Sexually Transmitted Diseases.* July 2004;31(7):424-427. Includes an assessment of CDC's dual treatment recommendations.

** Holmes K.K., Levine R. and Weaver M. "Effectiveness of Condoms in Preventing Sexually Transmitted Infections." *Bulletin of the World Health Organization.* June 2004;82(6):454-461.

** Piot P., Feachem R.G.A., Jong-wook L. and Wolfensohn J.D. "A Global Response to AIDS: Lessons Learned, Next Steps." *Science.* June 25, 2004;304:

** Hart T., Peterson J.L. and The Community Intervention Trial for Youth Study Team. "Predictors of Risky Sexual Behavior Among Young African American Men Who Have Sex With Men." *American Journal of Public Health.* July 2004;94(7):1122-1123. Non-supportive peer norms and not carrying condoms predicted risky sexual behavior.

*** Aberg J.A., Gallant J.E., Anderson J. and others. "Primary Care Guidelines for the Management of Persons Infected With Human Immunodeficiency Virus: Recommendations of the HIV Medicine Association of the Infectious Disease Society of America." *Clinical Infectious Diseases.* September 1, 2004;39(5):609-629.

** Di Clemente R.J., Wingood G.M., Harrington K.F. and others. "Efficacy of an HIV Prevention Intervention for African American Adolescent Girls." *JAMA.* July 14, 2004;292(2):171-179. Randomized, controlled trial of 522 girls with 6 and 9-month follow-up.

** Foss A.M., Watts C.H. and Vickerman P. "Condoms and Prevention of HIV." *British Medical Journal.* July 24, 2004;329:185-186.

** Abdullah A.S.M., Ebrahim S.H., Fielding R. and Morisky D.E. "Sexually Transmitted Infections in Travelers: Implications for Prevention and Control." *Clinical Infectious Diseases.* August 15, 2004. 39(4):533-538.

*** Weinhardt L.S., Kelly J.A., Brondino M.J. and others. "HIV Transmission Risk Behavior Among Men and Women Living With HIV in 4 Cities in the United States." *Journal of Immune Deficiency Syndromes.* August 15, 2004;36(5):1057-1066. The need for intensive prevention programs.

*** Marcus U., Zucs P., Bremer V. and others. "Shigellosis - - A Re-emerging Sexually Transmitted Infection: Outbreak in Men Having Sex with Men in Berlin." *International Journal of STD and AIDS.* August 2004;15:533-537. The authors cite the need for travel histories and awareness of asymptomatic shedding.

**** Doms R.W. "Viral Entry Denied." *New England Journal of Medicine.* August 19, 2004 ; 351(8):743-744. Brief overview of how entry inhibitor drugs work and their application to HIV infection.

*** Zambrana R.E., Cornelius L.J., Boykin S.S. and others. "Latinas and HIV/AIDS Risk Factors: Implications for Harm Reduction Strategies." *American Journal of Public Health."* July 2004;94(7):1152-1158.

*** Bolu O.O., Lindsey C., Kamb M.L. and others. "Is HIV/Sexually Transmitted Disease Prevention Counseling Effective Among Vulnerable Populations? A Subset Analysis of Data Collected for a Randomized, Controlled Trial Evaluating Counseling Efficacy (Project RESPECT)" *Sexually Transmitted Diseases.* August 2004;31(8):459-474. Yes, according to the authors.

* McNeil D.G. "Facing Middle Age and AIDS." *New York Times.* August 17, 2004, Science Times, page D1 and D6. Includes review of epidemiology, denial, late diagnosis, HIV-geriatric medication interactions.

*** Springer S.A., Pesanti E., Hodges J. and others. "Effectiveness of Antiretroviral Therapy among HIV-Infected Prisoners: Re-incarceration and the Lack of Sustained Benefit after Release to the Community." *Clinical Infectious Diseases.* June 15, 2004;38(12):1754-1760. HAART use resulted in impressive outcomes (59% achieved undetectable HIV RNA) during incarceration, recidivism to prison was high and associated with a poor outcome.

** Wilson I. "The Challenge of Understanding Articles about Health-Related Quality of Life." *Clinical Infectious Diseases.* August 1, 2004;39(3):434-435.

*** Gerber M.T., Mondy K.E., Yarasheski K.E. and others. "Niacin in HIV-Infected Individuals with Hyperlipidemia Receiving Potent Antiretroviral Therapy." *Clinical Infectious Diseases.* August 1, 2004;39(3):419-425.

** Gambert S.R. "Physician's Perspective: Tuberculosis: An Old Disease Returns." *Clinical Geriatrics.* 2004;12(8):9-10. Case notes on the masquerades of TB.

** Nelson L.J., Schneider E.,Wells C.D. and others. "Epidemiology of Childhood Tuberculosis in the United States, 1993-2001: The Need for Continued Vigilance." *Pediatrics.* August 2004;114(2):333-341.

*** Jasmer R.M., Seaman C.B., Gonzalez L.C. and others. "Tuberculosis Treatment Outcomes: Directly Observed Therapy Compared with Self-Administered Therapy." *American Journal of Respiratory Care and Critical Care Medicine.* September 2004;170(5):561-566. The authors of this San Francisco General study conclude that treatment plans emphasizing DOT from the start of therapy have the greatest success in improving outcomes.

*** van Hest R., Baara H., Kid S. and others. "Hepatotoxicity of Rifampin-Pyrazinamide and Isoniazid Preventive Therapy and Tuberculosis Treatment." *Clinical Infectious Diseases.* August 15, 2004;39(4):488-496.

*** Gordin F.M., Cohn D.L., Matts J.P. and others. "Hepatotoxicity of Rifampin and Pyrazinamide in the Treatment of Latent Tuberculosis Infection in HIV-Infected Persons: Is It Different Than in HIV-Uninfected Persons? " *Clinical In-*

fectious Diseases. August 15, 2004;39(4):561-565.

** Saukkonin J. Rifampin and Pyrazinamide for Latent Tuberculosis Infection: Clinical Trials and General Practice." *Clinical Infectious Diseases* August 15, 2004; 566-568. This editorial discusses the results of the TB research listed above.

**** Nardell E.A., Fan D., Shepard J.O. "Case 22-2004: A 30-Year-Old Woman with a Pericardial Effusion." *New England Journal of Medicine.* July 15, 2004;351(3):279-287. Differential diagnosis for a medical student with a history of travel, equivocal skin test and TB.

*** Giordano T.P., Soini H., Teeter L.D. and others. "Relating the Size of Molecularly Defined Clusters of Tuberculosis to the Duration of Symptoms." *Clinical Infectious Diseases.* January 1, 2004;38(1):1-6.

*** Brock I., Weldingy K., Lillebaek T. and others. "Comparison of Tuberculin Skin Test and New Specific Blood Test in Tuberculosis Contacts." *American Journal of Respiratory Care and Critical Care Medicine.* 200r;170:65-69.

*** Bain V.G., Bonacini M., Govindarajan S. and others. "A Multicenter Study of the Usefulness of Liver Biopsy in Hepatitis C." *Journal of Viral Hepatitis.* July 2004;11(4):375-382. Clinicians predicted the inflammatory grade in 55%, and the fibrosis stage of 57% of 81 cases. Nine of 17 cirrhotic cases were predicted. The authors of this US/Canadian study conclude that biopsy remains essential for accurate stage and grade evaluation.

*** Pawlotsky J-M. "Treating Hepatitis C in "Difficult-to-Treat" Patients." *New England Journal of Medicine.* July 29, 2004;351(5):422-423. Failure to achieve sustained virologic response and treatment schedules, host factors, disease-related characteristics and viral factors.

*** Kottilil S., Polis M.A. and Kovacs J.A. "HIV Infection, Hepatitis C Infection, and HAART: Hard Clinical Choices." *JAMA.* July 14, 2004;292(2):243-250. Individualized treatment is needed to maximize benefits and tolerance.

*** Morroni C., Grams M., Tiezzi, L. and Westhoff C. "Immediate Monthly Combination Contraception to Facilitate Initiation of the Depot Medroxyprogesterone Acetate Contraception Injection." *Contraception.* July 2004:70(1):19-23. 85% of clients were satisfied with this bridge to DMPA .

*** Ness R.B., Randall H., Peipert J.F. and others. "Condom Use and the Risk of Recurrent Pelvic Inflammatory Disease, Chronic Pelvic Pain, or Infertility Following an Episode of Pelvic Inflammatory Disease." *American Journal of Public Health.* August 2004;94(8):1327-1329. Self reported persistent and consistent condom use was associated with lower rates of PID sequelae.

*** Ross J.D.C. "What Is Endometritis and Does It Require Treatment?" *Sexually Transmitted Infections."* August 2004;80(4):252-253.

*** Sidney S., Petitti D.B., Soff G.A. and others. "Venous Thromboembolic Disease in Users of Low-Estrogen Combined Estrogen-Progestin Oral Contraceptives." *Contraception.* July 2004;70(10):3-10. The risk of VTE is increased in users of low-estrogen formulations and obese women appear to be at greater risk.

** Brody J.E. "The Politics of Emergency Contraception." *New York Times.* Tuesday, August 24. Page D7. American College of Obstetrics and Gynecology and other medical and nursing professional associations vs. politicians.

**** Peto J., Gilham C. and Fletcher O. "The Cervical Cancer Epidemic that Screening Has Prevented in the UK." *The Lancet.* July 17, 2004;364:249-256. Screening, cost benefit, and the value of early education and screening.

*** Gustafsson L., Leijonhufvud I., Arronsson A. and others. "Treatment of Skin Papillomas with Topical α-Lactabumin-Oleic Acid." *New England Journal of Medicine.* June 24,2004;350(26):2663-2672. Preliminary investigation of human milk derivative as a treatment for papillomas and other tumors. The proposed mechanism of action does not require an immune response, hence the hope for improved treatment for immunocompromised patients.

** Kurth A., Whittington W.L.H., Golden M.R. and others. "Performance of a New, Rapid Assay for Detection of Trichomonas vaginalis." *Journal of Clinical Microbiology.* July 2004;42(7):2940-2943. The Xenostrip assay was more sensitive but less specific than a wet prep. Sensitivity did decline for every additional day of delay until *T. vaginalis* was first detected in cultures.

*** "Tinidazole (Tindamax) – A New Anti-Protozoal Drug." *The Medical Letter.* August 30, 2004;46(1190):70-72. Includes prices such as $2.88 for generic metronidazole, $18.24 for Tindamax and a review of research on this new drug.

** Santelli J.S., Abma J., Ventura S., and others. "Can Changes in Sexual Behaviors Among High School Students Explain the Decline in Teen Pregnancy Rates in the 1990s?" *Journal of Adolescent Health.* August 2004;35(2):80-90. CDC article attributing 53% of the decline to decreased sexual experience and 47% to improved contraceptive use for the years 1995-2001. The article is available at **http://www.teenpregnancy.org.**

*** T.Tamkins. "Teenagers Who Abstain from Sex Cite Similar Reasons Regardless of Whether They Have Ever Had Intercourse." *Perspectives on Sexual and Reproductive Health.* July/August 2004;36(4). unpaginated. **http://www.agi-usa.org/journals/toc/psrh3604toc.html**

** Drumright L.N., Gorbach P.M. and Holmes K.K. "Do People Really Know Their Sex Partners? Concurrency, Knowledge of Partner Behavior, and Sexually Transmitted Infections Within Partnerships." *Sexually Transmitted Diseases.* July 2004;31(7):437-442. Only 26% of individuals whose partners had other partners were aware of this.

** "What Medications Counteract The Pill?" *Contraceptive Technology Update.* October 2004;25(10) 119. Some anticonvulsants including some used for migraine, bipolar disorder, and chronic pain syndromes. Rifampin. Nyquil and its equivalents. Consider condom backup for some antibiotics.

** Crosby R.A., Graham C.A. and Yarber W.L. "If The Condom Fits, Wear It: A Qualitative Study of African-American Men." *Sexually Transmitted Infections.* August 2004;80(4):306-309. Excellent material for counseling and clinical students or those attempting to lead discussion groups at drug treatment or incarceration/post-incarceration sites with any group of males or females.

*** Swider S.M. and Valukas A. "Options for Sustaining School-Based Health Centers." *Journal of School Health.* April 2004;74(4):115-118. Funding specifics. Includes pros and cons of federal, state, local and private sources.

*** "Methamphetamine Abuse." *The Medical Letter.* August 2, 2004;46(1188):62-63. Brief overview and reminder of drug interactions such as those with retonavir (Norvir) and severe reactions with MAO inhibitors.

** "Performance-Enhancing Drugs." *The Medical Letter.* July 19, 2004;46(1187):57-59. List and brief description. An alert for those who work with teens or athletes. Reminder that those who use banned substances may share needles.

For single copies of the articles listed above, please contact Bonnie Nickle at (360) 236-3460.

Other Health Resources

HIV

Public Health - Seattle & King County presents a social marketing campaign that aims to reduce the stigma associated with HIV and acknowledges the powerful role that people who are positive have in ending the epidemic. The campaign celebrates the contributions that are made every day by those most affected by the disease. Visit **http://www.metrokc.gov/health/apu/#new.**

A warning notice from the FDA has been issued to an internet site selling the product "**Eurocel**." The manufactures are making false therapeutic claims about this product as it relates to HIV/AIDS and hepatitis C treatment.

The FDA has issued a warning about internet advertisements for the dietary supplement **Viralsol**. The manufacturer promotes this product as a cure for HIV/AIDS, hepatitis, herpes and influenza. This product is not recognized as safe and effective for its advertised use.

The **Northwest AIDS Education and Training Center and the University of Washington** are pleased to announce the release of their new web site **www.hivwebstudy.org**. This web site features 40 interactive case studies that cover a broad array of topics related to the clinical care of HIV-infected persons. Each topic includes case studies, discussion points, high-quality illustrations and graphics, references, and links. In addition, the site offers **free CME credit** for MD, PA, NP, and Pharmacists. Hivwebstudy.org is funded by the Health Resources and Services Administration (HRSA), US Department of Health and Human Services.

The **Northwest AIDS Education and Training Center** offers **healthcare providers** in Washington state a wide variety of education and training opportunities. These include: general HIV updates; discipline-specific updates; trainings related to the medical and pharmacological treatment and management of HIV; and, one-on-one preceptorships for primary care providers, nurses, pharmacists, dieticians, and dental providers. Clinical consultation services are available to providers actively engaged in HIV care provision. For information about training opportunities, please contact Robert Carroll at 206-685-0226; email **carrollr@u.washington.edu**.; or, visit **www.northwestaetc.org.**

The **Food and Drug Administration** has developed a web page to consolidate records of advisory committee meetings related to HIV/AIDS and associated conditions, making them easier to access. The new page, which lists HIV/AIDS-related advisory committee meetings held since 1996, indexed by topic and by year, can be found at **http://www.fda.gov/oashi/aids/advisorycom.html**. The page is linked from the main HIV/AIDS page at **http://www.fda.gov/oashi/aids/hiv.html.**

The Body features two articles of merit: "**The Disclosure Dilemma**" by Dr. J. Buzz von Ornsteiner, and "**Mixed HIV Status Couples: Moving From Research to Practice**" by José-María Medellín and Robert H. Remien. The first article offers thoughtful comments on the challenging topic of disclosure, and the second article presents discussion on research from the HIV Center for Clinical and Behavioral Studies in New York City, including various aspects of health and prevention affecting discordant couples.

Washington State Guidance for HIV/AIDS Prevention Case Management and Individual Level HIV Counseling is now on the Washington Department of Health Website. This document consists of guidance for the development, implementation, and management of two separate HIV prevention interventions: **HIV Prevention Case Management** (PCM), and **Individual Level HIV Counseling.** Visit **http://www.doh.wa.gov/cfh/HIV_AIDS/Prev_Edu/default.htm.**

HRSA/HAB has developed a new 24-hour clinical consultation service, the **National Perinatal HIV Consultation and Referral Service (Perinatal Hotline). This** service provides **24-hour advice from HIV experts** on indications and interpretations of HIV testing in pregnancy as well as consultation on treating HIV-infected pregnant women and their infants. Callers are referred to a national network of education, training and consultation services available from regional AIDS Education and Training Centers (AETCs). The Perinatal Hotline is an expansion of the HRSA National HIV/AIDS Clinicians' Consultation Center (NCCC) at San Francisco General Hospital, which currently operates the National HIV Telephone Consultation Service (Warmline) and the National Clinicians' Post-Exposure Prophylaxis Hotline (PEPline). The **Perinatal Hotline (888-448-8765)** and the **PEPline (888-448-4911)** are both available 24 hours, seven days per week. The Warmline (800-933-3413) is available 8 a.m. to 8 p.m. (EST) Monday through Friday.

People living with HIV (PLWH) may travel for business or pleasure, so finding resources on safe travel practices for PLWH is important. HIV-infected individuals carry a greater risk of contracting infections and diseases than non-HIV infected individuals. In response to this need, AIDSinfo created the Traveler's Health page on its web site. This page provides links to federally approved information regarding health and safety precautions for travelers with compromised immune systems. AIDSinfo is a U.S. Department of Health and Human Services (DHHS) project providing information on HIV/AIDS clinical trials and treatment. To access the Traveler's Health web page go to: **http://www.aidsinfo.nih.gov/other/hivtravel/hivtravel.html.**

STD Prevention, Family Planning and Reproductive Health

An Interview with Melissa Palmer, MD on her book, **Dr. Melissa Palmer's Guide to Hepatitis & Liver Disease** is featured in the Medical Advocates' Thoughtleaders series. Dr. Palmer discusses in detail the current therapies for HIV/HCV coinfection, new agents in development, and nutritional supplements. Chapters on Herbs and Other Alternative Therapies and Diet, Nutrition and Exercise provide an important professional assessment of adjunct therapies not often well integrated into some medical practices. Visit: **www.medadvocates.org/resources/thoughtleaders.**

United States Health Resources Services Administration (HRSA) has just issued the **Women's Health USA 2003 Data Book**. This publication is intended to be a concise reference with current data on significant issues in women's health. Included are data on: utilization of health service; drug and alcohol use behaviors; special populations; and health indicators such as AIDS and STD. The report is available at: **http://www.hrsa.gov/womenshealth/databook.htm.** You may order hard copies from the HRSA Information Center at 1-888-ASK-HRSA, or visit: **http://www.ask.hrsa.gov/.**

"**It's a man thing, but is health apathy the right thing?" Lowell Davis, MD,** an African American surgeon writes of his personal experiences with health problems in the male health section of the Mayo Clinic web site. STD, HIV, hepatitis, birth control, prostate exams, gathering information for health histories, suggestions for tests by age and behavior, and other topics are also featured in the men's section. The consumer section uses a sensible, detailed "when, why, and how often" format. Evaluations of alternative treatments, prescription medications, and comprehensive information on medical/lab

tests and what the results might mean are also noted at the Mayo Clinic site. Visit: **http://www.mayoclinic.com/invoke.cfm?objectid=FA345E73-52B1-4019-B341BB1B2A3DBBC6**

"**Effectiveness of condoms in preventing sexually transmitted infections" Bulletin of the World Health Organization** 2004, 82:454-461" While the effectiveness of condoms in STI prevention is not 100%, the authors conclude from the review that "condom promotion represents an important component of comprehensive HIV and STI-prevention strategies." Get full report from: **http://www.who.int/bulletin/volumes/82/6/en/454.pdf.**

The **Ready-to-Use STD Curriculum** for Clinical Educators is now available through the CDC internet website. This site provides STD curricular materials which can be downloaded for use in the clinical training classroom. To access the Ready-to-Use STD Curriculum, click on the following link: **http://www.cdc.gov/std/** -- the curriculum is the first highlighted item. You can also access it from the STD home page by clicking on "Training" and then "Other Resources."

Resources in Spanish

AIDSmeds.com/español online: **http://www.aidsmeds.com/espanol/. www.aidsmeds.com** has translated part of its site information into Spanish. This is a drug company-sponsored site, but it features a variety of opinions on medication issues. The English version of the site has HIV+ chat room monitors who are kind to HIV+ newcomers, people in rural areas, and those struggling with testing, diagnosis, medication adherence, treatment decisions, confidentiality in small towns, and other topics.

AIDSinfo's fact sheets designed for consumers, "**Side Effects of Anti-HIV Medications,**" are now available **in Spanish.** This series of fact sheets discusses some of the major side effects of anti-HIV medications. The information in these fact sheets is based on "Guidelines for the Use of Antiretroviral Agents in HIV-Infected Adults and Adolescents" and "Management of Metabolic Complications Associated with Antiretroviral Therapy for HIV-1 Infection: Recommendations of an International AIDS Society-USA Panel." To view the Spanish version of the fact sheets go to: **http://aidsinfo.nih.gov/other/sideeffectshiv/spanish/sideeffectshiv_sp.html.**

TB

The Francis J. Curry National TB Center has updated its self-study online course on TB and HIV. "**TB and HIV: An Online Course for Clinicians"** describes the transmission, pathogenesis, epidemiology, screening, diagnosis, and treatment of TB and HIV-1 co-infection, including information on treatment of latent tuberculosis infection and treatment of active tuberculosis disease in the presence of protease inhibitors. A set of brief "review cases" and a full-length interactive "case study" challenge the user to apply the content they have learned in the text. To take the course, open the following link: **http://www.nationaltbcenter.edu/tbhiv_course**. The course is approved for 1.0 continuing medical education hours and 2.4 continuing education credits for nurses. Credit is awarded to clinicians with a U.S. license only.

For free copies of laminated, pocket-sized summaries of **"Treatment of Tuberculosis: Standard Therapy for Active Disease in Adults 2004," "Treatment of TB in Adult and Adolescent Patients Co-infected with HIV 2004,"** and **"Treatment of Tuberculosis: Standard Therapy for Active Disease in Children and Adolescents 2004,"** fax an order to the National Tuberculosis Center, (973) 972-3268. Include a statement as to your clinical specialty and how you will use these materials. The center also maintains a **TB information hotline for clinicians** at 1-800-4TB-DOCS. The Center's phone number is (973) 972-3270.

OTHER

http://americanindianhealth.nlm.nih.gov/tribes.html is the web site for American Indian Health at the National Library of Medicine Web Site. Some Washington state Tribes are listed.

Rebecca Minnich's article, "Don't Mess With These Girls, " describing the experience of some transgender people with the medical system is available at **POZ magazine's** site in the August issue. Visit: **http://www.poz.com/index.cfm?p=article&art_id=3456.**

The CDC-sponsored Black AIDS Institute (BAI) is now accepting applications for its African-American HIV University, a comprehensive training and internship program designed to decrease stigma and misperception, and increase HIV science literacy in Black communities. Applications must be submitted by the close of business, February 11, 2005. Visit: **http://www.blackaids.org/**,

http://www.popcouncil.org/pdfs/popsyn/PopulationSynthesis2.pdf is the site for the **Population Council's** report on young men's experiences as victims and perpetrators of sexual coercion. **www.popcouncil.org/pdfs/popsyn/PopulationSynthesis3.pdf** is the Council's report on the adverse health and social outcomes of sexual coercion as it affects young women in developing countries.

WASHINGTON STATE HIV/AIDS SURVEILLANCE REPORT – 10/31/2004
WASHINGTON STATE DEPARTMENT OF HEALTH
TECHNICAL NOTES

Dear Readers:

In this month's edition of the HIV/AIDS Surveillance Report, you will notice that the number of AIDS cases has decreased substantially compared to the numbers report last month. The purpose of these technical notes is to explain the decrease, which is a result of Washington State's participation in a national effort to de-duplicate the national HIV/AIDS database.

THE PROBLEM

- All states and areas have been reporting AIDS cases since 1986 or earlier.
- For surveillance purposes, AIDS cases have always been counted as belonging to the geographic area where they were diagnosed with AIDS (which may not reflect where they currently reside and receive services). If, for example, someone was first diagnosed with AIDS in Washington and then moved to Oregon, they would still be counted as a Washington case. If the person moved to Oregon and did not tell their health care provider they had been previously diagnosed in Washington, the case would be counted in both states, resulting in duplication and contributing to artificial inflation of case numbers at the national level.
- Duplication of cases could be a problem because surveillance data are used to both track the epidemic and allocate Ryan White Care (RWCA) funds. For accurate tracking and allocation, people with AIDS should be counted only once.

THE SOLUTION

- To counter the potential problem, the Centers for Disease Control and Prevention (CDC) initiated the Interstate De-duplication Project (IDEP) in 2002. CDC identified potential duplicates in the national database. Since they do not receive names of those with AIDS, they sent the information to states, who worked together to identify which cases were duplicates and which were not. For Washington State, only AIDS cases were included in the de-duplication exercise because CDC does not yet accept HIV data from the state.
- Results to date show that while duplicates exist, the number of duplicates at the national level was approximately 5%, no higher than expected. This indicates that surveillance practices to minimize duplication have been effective.
- Duplicates identified through this process need to be assigned a correct state of residence at AIDS diagnosis. In total, 1,063 Washington State AIDS cases were determined to be the same person as at least one other state's case. As a result of this exercise, 658 Washington State cases were retained with a local AIDS diagnosis residence and 405 cases were assigned an Out of State diagnosis residence; consequently, 405 fewer cases appear on this surveillance report.
- In the future, CDC and states will work together to conduct de-duplication on a quarterly basis. When CDC includes Washington State's HIV cases in the national database, they will be included in this exercise.
- Since RWCA funding is based on 10 years of data, any change in AIDS cases in any given year will not greatly affect funding. In addition, a "hold harmless" clause also prevents major reductions in funding where case counts for a grantee might change dramatically in a reporting period.

If you have any questions about the surveillance report or the de-duplication exercise, please contact Maria Courogen, Infectious Disease and Reproductive Health Assessment Unit, at (360) 236-3458.

TABLE 1. WASHINGTON STATE HIV[1] AND AIDS CASES DIAGNOSED, KNOWN DEATHS, AND CASES PRESUMED LIVING, AS OF 10/31/2004

	TOTAL CASES (& CASE FATALITY RATE[2]) DIAGNOSED DURING INTERVAL[3]					DEATHS OCCURRING DURING INTERVAL[4]		CASES PRESUMED LIVING DIAGNOSED DURING INTERVAL[3]		
	HIV[1]		AIDS		**HIV/AIDS**	*HIV[1]*	AIDS	*HIV[1]*	AIDS	**HIV/AIDS**
	No.	*(%)*	No.	(%)	**Total**	*No.*	No.	*No.*	No.	**Total**
1982	*3*	*(0%)*	1	(100%)	**4**	*0*	0	*3*	0	**3**
1983	*6*	*(17%)*	20	(100%)	**26**	*0*	7	*5*	0	**5**
1984	*13*	*(0%)*	79	(97%)	**92**	*0*	31	*13*	2	**15**
1985	*67*	*(9%)*	132	(97%)	**199**	*0*	81	*61*	4	**65**
1986	*62*	*(13%)*	245	(98%)	**307**	*0*	126	*54*	6	**60**
1987	*74*	*(12%)*	369	(95%)	**443**	*2*	187	*65*	17	**82**
1988	*82*	*(13%)*	493	(93%)	**575**	*6*	236	*71*	33	**104**
1989	*124*	*(11%)*	612	(91%)	**736**	*8*	308	*110*	54	**164**
1990	*141*	*(13%)*	733	(90%)	**874**	*6*	371	*123*	74	**197**
1991	*153*	*(8%)*	836	(86%)	**989**	*4*	461	*141*	118	**259**
1992	*142*	*(8%)*	897	(76%)	**1,039**	*7*	515	*130*	212	**342**
1993	*128*	*(5%)*	945	(66%)	**1,073**	*12*	618	*122*	319	**441**
1994	*175*	*(5%)*	852	(55%)	**1,027**	*5*	664	*166*	387	**553**
1995	*183*	*(3%)*	753	(37%)	**936**	*5*	653	*177*	477	**654**
1996	*223*	*(3%)*	662	(25%)	**885**	*3*	469	*216*	495	**711**
1997	*224*	*(5%)*	508	(19%)	**732**	*7*	221	*213*	413	**626**
1998	*221*	*(2%)*	383	(22%)	**604**	*5*	161	*216*	298	**514**
1999	*280*	*(2%)*	352	(20%)	**632**	*4*	130	*275*	281	**556**
2000	*352*	*(3%)*	431	(19%)	**783**	*29*	154	*343*	351	**694**
2001	*315*	*(1%)*	402	(12%)	**717**	*21*	139	*312*	352	**664**
2002	*316*	*(1%)*	436	(8%)	**752**	*17*	137	*312*	400	**712**
2003[5]	*328*	*(0%)*	432	(6%)	**760**	*13*	157	*327*	408	**735**
2004 YTD[5]	233	*(0%)*	258	(3%)	**491**	4	55	232	249	**481**
TOTAL	*3,845*	*(4%)*	10,831*	(54%)	**14,676**	*158*	5,881	*3,687*	4,950*	**8,637**

TABLE 2. WASHINGTON STATE HIV[1] AND AIDS CASES, GENDER BY AGE AT DIAGNOSIS.

	HIV[1]						AIDS					
	Male		*Female*		*Total*		Male		Female		Total	
	No.	*(%)*	*No.*	*(%)*	*No.*	*(%)*	No.	(%)	No.	(%)	No.	(%)
Under 13	*18*	*(0%)*	*21*	*(1%)*	*39*	*(1%)*	15	(0%)	17	(0%)	32	(0%)
13-19	*61*	*(2%)*	*38*	*(1%)*	*99*	*(3%)*	29	(0%)	11	(0%)	40	(0%)
20-29	*1,078*	*(28%)*	*210*	*(5%)*	*1,288*	*(33%)*	1,607	(15%)	220	(2%)	1,827	(17%)
30-39	*1,374*	*(36%)*	*176*	*(5%)*	*1,550*	*(40%)*	4,592	(42%)	371	(3%)	4,963	(46%)
40-49	*598*	*(16%)*	*92*	*(2%)*	*690*	*(18%)*	2,634	(24%)	209	(2%)	2,843	(26%)
50-59	*134*	*(3%)*	*22*	*(1%)*	*156*	*(4%)*	780	(7%)	80	(1%)	860	(8%)
60+	*18*	*(0%)*	*5*	*(0%)*	*23*	*(1%)*	235	(2%)	31	(0%)	266	(2%)
TOTAL	*3,281*	*(85%)*	*564*	*(15%)*	*3,845*	*(100%)*	9,892*	(91%)	939*	(9%)	10,831*	(100%)

1 Includes persons reported with HIV infection who are not known to have progressed to AIDS as of this report date. Does not include those who have only been tested anonymously for HIV.

2 Case fatality rate is the proportion of HIV or AIDS patients diagnosed during interval who are known to have died at some time since diagnosis.

3 Year of diagnosis reflects the time at which HIV infection or AIDS was diagnosed by a health care provider. Year of report (not shown above) reflects the time at which a case report was received by the Department of Health.

4 Includes deaths among HIV or AIDS patients diagnosed during that interval or any preceding interval.

5 Reporting delay is the period between the date a reportable disease is diagnosed by a physician and the date that the diagnosis is reported to public health officials. Cases counts for more recent time periods are considered to be incomplete due to reporting delays.

* For explanation of revised AIDS total, see technical notes

IDRH Assessment Unit, P.O. Box 47838, Olympia, WA 98504-7838; (360) 236-3455.

TABLE 3. WASHINGTON STATE HIV[1] CASES, RACE/ETHNICITY[10] AND EXPOSURE CATEGORY, AS OF 10/31/2004

	Adult/Adolescent				Pediatric		Total	
	Male	(%)	Female	(%)	No.	(%)	No.	(%)
Race/Ethnicity[10]								
White, not Hispanic	2505	(77%)	281	(52%)	14	(36%)	2800	(73%)
Black, not Hispanic	367	(11%)	168	(31%)	15	(38%)	550	(14%)
Hispanic (All Races)	246	(8%)	46	(8%)	6	(15%)	298	(8%)
Asian/Pacific Islander	3	(0%)	4	(1%)	0	(0%)	7	(0%)
Asian	71	(2%)	10	(2%)	4	(10%)	85	(2%)
Hawaiian/Pacific Islander	4	(0%)	1	(0%)	0	(0%)	5	(0%)
Native American/Alaskan	35	(1%)	29	(5%)	0	(0%)	64	(2%)
Multi-race	12	(0%)	1	(0%)	0	(0%)	13	(0%)
Unknown	20	(1%)	3	(1%)	0	(0%)	23	(1%)
Total	3,263	(100%)	543	(100%)	39	(100%)	3,845	(100%)
Exposure Category								
Male/male sex (MSM)	2397	(73%)	N/A	( )	0	(0%)	2397	(62%)
Injecting Drug Use (IDU)	235	(7%)	139	(26%)	0	(0%)	374	(10%)
MSM and IDU	322	(10%)	N/A	( )	0	(0%)	322	(8%)
Transfusion/Transplant	7	(0%)	9	(2%)	0	(0%)	16	(0%)
Hemophilia	12	(0%)	1	(0%)	1	(3%)	14	(0%)
Heterosexual Contact[6]	115	(4%)	272	(50%)	0	(0%)	387	(10%)
Mother at Risk for HIV	0	(0%)	0	(0%)	35	(90%)	35	(1%)
No Identified Risk[7]/Other	175	(5%)	122	(22%)	3	(8%)	300	(8%)
Total	3,263	(100%)	543	(100%)	39	(100%)	3,845	(100%)

1. Includes persons reported with HIV infection who are not known to have progressed to AIDS as of this report date. Does not include those who have only been tested anonymously for HIV.
6. Heterosexual Contact with a person who is known to be HIV infected or at increased risk for HIV infection.
7. No Identified Risk includes patients for whom risk information is incomplete, cases still under investigation, and interviewed patients with no recognized HIV exposure category.
10. Collection and presentation of race/ethnicity data have been adjusted to be consistent with Census 2000 data collection and presentation methods. Consequently, data for Asian/Pacific Islanders are now collected and presented in two separate categories ("Asian" and "Hawaiian/Pacific Islander"), while historical data are presented in the "Asian/Pacific Islander" category. Those who report more than one race are presented in the "Multi-race" category.

TABLE 4. WASHINGTON STATE AIDS CASES, RACE/ETHNICITY[10] AND EXPOSURE CATEGORY, AS OF 10/31/2004

	Adult/Adolescent				Pediatric		Total	
	Male	(%)	Female	(%)	No.	(%)	No.	(%)
Race/Ethnicity[10]								
White, not Hispanic	7888	(80%)	521	(57%)	15	(47%)	8424	(78%)
Black, not Hispanic	935	(9%)	239	(26%)	10	(31%)	1184	(11%)
Hispanic (All Races)	705	(7%)	79	(9%)	4	(13%)	788	(7%)
Asian/Pacific Islander	32	(0%)	12	(1%)	1	(3%)	45	(0%)
Asian	110	(1%)	15	(2%)	0	(0%)	125	(1%)
Hawaiian/Pacific Islander	20	(0%)	6	(1%)	0	(0%)	26	(0%)
Native American/Alaskan	153	(2%)	44	(5%)	1	(3%)	198	(2%)
Multi-race	24	(0%)	3	(0%)	1	(3%)	28	(0%)
Unknown	10	(0%)	3	(0%)	0	(0%)	13	(0%)
Total	9,877*	(100%)	922*	(100%)	32*	(100%)	10,831*	(100%)
Exposure Category								
Male/male sex (MSM)	7235	(73%)	N/A	( )	0	(0%)	7235	(67%)
Injecting Drug Use (IDU)	709	(7%)	274	(30%)	0	(0%)	983	(9%)
MSM and IDU	1066	(11%)	N/A	( )	0	(0%)	1066	(10%)
Transfusion/Transplant	72	(1%)	50	(5%)	0	(0%)	122	(1%)
Hemophilia	82	(1%)	4	(0%)	4	(13%)	90	(1%)
Heterosexual Contact[6]	271	(3%)	457	(50%)	0	(0%)	728	(7%)
Mother at Risk for HIV	0	(0%)	0	(0%)	28	(88%)	28	(0%)
No Identified Risk[7]/Other	442	(4%)	137	(15%)	0	(0%)	579	(5%)
Total	9,877*	(100%)	922*	(100%)	32*	(100%)	10,831*	(100%)

1. Includes persons reported with HIV infection who are not known to have progressed to AIDS as of this report date. Does not include those who have only been tested anonymously for HIV.
6. Heterosexual Contact with a person who is known to be HIV infected or at increased risk for HIV infection.
7. No Identified Risk includes patients for whom risk information is incomplete, cases still under investigation, and interviewed patients with no recognized HIV exposure category.
10. Collection and presentation of race/ethnicity data have been adjusted to be consistent with Census 2000 data collection and presentation methods. Consequently, data for Asian/Pacific Islanders are now collected and presented in two separate categories ("Asian" and "Hawaiian/Pacific Islander"), while historical data are presented in the "Asian/Pacific Islander" category. Those who report more than one race are presented in the "Multi-race" category.

* For explanation of revised AIDS total, see technical notes

TABLE 5. WA STATE HIV[1] & AIDS CASES DIAGNOSED, KNOWN DEATHS, AND CASES PRESUMED LIVING, BY COUNTY OF RESIDENCE[8] AT DIAGNOSIS, AS OF 10/31/2004

	CASES DIAGNOSED					DEATHS				PRESUMED LIVING				
	HIV[1]	*HIV[1]*	AIDS	AIDS	**HIV/AIDS**	*HIV[1]*	*HIV[1]*	AIDS	AIDS	*HIV[1]*	*HIV[1]*	AIDS	AIDS	**HIV/AIDS**
	No.	*(%)*	No.	(%)	**TOTAL**	*No.*	*(%)*	No.	(%)	*No.*	*(%)*	No.	(%)	**TOTAL**
REGION 1	*162*	*(4.2%)*	597	(5.5%)	**759**	*11*	*(7.0%)*	317	(5.4%)	*151*	*(4.1%)*	280	(5.7%)	**431**
ADAMS CO.	*1*	*(0.0%)*	5	(0.0%)	**6**	*0*	*(0.0%)*	1	(0.0%)	*1*	*(0.0%)*	4	(0.1%)	**5**
ASOTIN CO.	*4*	*(0.1%)*	13	(0.1%)	**17**	*1*	*(0.6%)*	6	(0.1%)	*3*	*(0.1%)*	7	(0.1%)	**10**
COLUMBIA CO.	*1*	*(0.0%)*	4	(0.0%)	**5**	*0*	*(0.0%)*	3	(0.1%)	*1*	*(0.0%)*	1	(0.0%)	**2**
FERRY CO.	*0*	*(0.0%)*	7	(0.1%)	**7**	*0*	*(0.0%)*	6	(0.1%)	*0*	*(0.0%)*	1	(0.0%)	**1**
GARFIELD CO.	*1*	*(0.0%)*	0	(0.0%)	**1**	*0*	*(0.0%)*	0	(0.0%)	*1*	*(0.0%)*	0	(0.0%)	**1**
LINCOLN CO.	*0*	*(0.0%)*	5	(0.0%)	**5**	*0*	*(0.0%)*	2	(0.0%)	*0*	*(0.0%)*	3	(0.0%)	**3**
OKANOGAN CO.	*6*	*(0.2%)*	25	(0.2%)	**31**	*0*	*(0.0%)*	8	(0.1%)	*6*	*(0.2%)*	17	(0.3%)	**23**
PEND OREILLE CO.	*1*	*(0.0%)*	8	(0.1%)	**9**	*0*	*(0.0%)*	5	(0.1%)	*1*	*(0.0%)*	3	(0.1%)	**4**
SPOKANE CO.	*136*	*(3.5%)*	448	(4.1%)	**584**	*9*	*(5.7%)*	248	(4.2%)	*127*	*(3.4%)*	200	(4.0%)	**327**
STEVENS CO.	*4*	*(0.1%)*	20	(0.2%)	**24**	*0*	*(0.0%)*	8	(0.1%)	*4*	*(0.1%)*	12	(0.2%)	**16**
WALLA WALLA CO.	*6*	*(0.2%)*	52	(0.5%)	**58**	*1*	*(0.6%)*	26	(0.4%)	*5*	*(0.1%)*	26	(0.5%)	**31**
WHITMAN CO.	*2*	*(0.1%)*	10	(0.1%)	**12**	*0*	*(0.0%)*	4	(0.1%)	*2*	*(0.1%)*	6	(0.1%)	**8**
REGION 2	*124*	*(3.2%)*	363	(3.4%)	**487**	*7*	*(4.4%)*	177	(3.0%)	*117*	*(3.2%)*	186	(3.8%)	**303**
BENTON CO.	*21*	*(0.5%)*	78	(0.7%)	**99**	*1*	*(0.6%)*	36	(0.6%)	*20*	*(0.5%)*	42	(0.8%)	**62**
CHELAN CO.	*14*	*(0.4%)*	35	(0.3%)	**49**	*1*	*(0.6%)*	21	(0.4%)	*13*	*(0.4%)*	14	(0.3%)	**27**
DOUGLAS CO.	*2*	*(0.1%)*	2	(0.0%)	**4**	*0*	*(0.0%)*	2	(0.0%)	*2*	*(0.1%)*	0	(0.0%)	**2**
FRANKLIN CO.	*17*	*(0.4%)*	43	(0.4%)	**60**	*1*	*(0.6%)*	14	(0.2%)	*16*	*(0.4%)*	29	(0.6%)	**45**
GRANT CO.	*9*	*(0.2%)*	30	(0.3%)	**39**	*1*	*(0.6%)*	19	(0.3%)	*8*	*(0.2%)*	11	(0.2%)	**19**
KITTITAS CO.	*3*	*(0.1%)*	15	(0.1%)	**18**	*0*	*(0.0%)*	8	(0.1%)	*3*	*(0.1%)*	7	(0.1%)	**10**
KLICKITAT CO.	*5*	*(0.1%)*	8	(0.1%)	**13**	*0*	*(0.0%)*	5	(0.1%)	*5*	*(0.1%)*	3	(0.1%)	**8**
YAKIMA CO.	*53*	*(1.4%)*	152	(1.4%)	**205**	*3*	*(1.9%)*	72	(1.2%)	*50*	*(1.4%)*	80	(1.6%)	**130**
REGION 3	*299*	*(7.8%)*	853	(7.9%)	**1,152**	*17*	*(10.8%)*	438	(7.4%)	*282*	*(7.6%)*	415	(8.4%)	**697**
ISLAND CO.	*17*	*(0.4%)*	58	(0.5%)	**75**	*1*	*(0.6%)*	33	(0.6%)	*16*	*(0.4%)*	25	(0.5%)	**41**
SAN JUAN CO.	*6*	*(0.2%)*	17	(0.2%)	**23**	*0*	*(0.0%)*	10	(0.2%)	*6*	*(0.2%)*	7	(0.1%)	**13**
SKAGIT CO.	*25*	*(0.7%)*	50	(0.5%)	**75**	*4*	*(2.5%)*	28	(0.5%)	*21*	*(0.6%)*	22	(0.4%)	**43**
SNOHOMISH CO.	*208*	*(5.4%)*	582	(5.4%)	**790**	*10*	*(6.3%)*	291	(4.9%)	*198*	*(5.4%)*	291	(5.9%)	**489**
WHATCOM CO.	*43*	*(1.1%)*	146	(1.3%)	**189**	*2*	*(1.3%)*	76	(1.3%)	*41*	*(1.1%)*	70	(1.4%)	**111**
REGION 5	*424*	*(11.0%)*	1,146	(10.6%)	**1,570**	*26*	*(16.5%)*	635	(10.8%)	*398*	*(10.8%)*	511	(10.3%)	**909**
KITSAP CO.	*69*	*(1.8%)*	194	(1.8%)	**263**	*1*	*(0.6%)*	108	(1.8%)	*68*	*(1.8%)*	86	(1.7%)	**154**
PIERCE CO.	*355*	*(9.2%)*	952	(8.8%)	**1,307**	*25*	*(15.8%)*	527	(9.0%)	*330*	*(9.0%)*	425	(8.6%)	**755**
REGION 6	*297*	*(7.7%)*	897	(8.3%)	**1,194**	*12*	*(7.6%)*	451	(7.7%)	*285*	*(7.7%)*	446	(9.0%)	**731**
CLALLAM CO.	*16*	*(0.4%)*	49	(0.5%)	**65**	*2*	*(1.3%)*	27	(0.5%)	*14*	*(0.4%)*	22	(0.4%)	**36**
CLARK CO.	*129*	*(3.4%)*	393	(3.6%)	**522**	*2*	*(1.3%)*	198	(3.4%)	*127*	*(3.4%)*	195	(3.9%)	**322**
COWLITZ CO.	*31*	*(0.8%)*	89	(0.8%)	**120**	*1*	*(0.6%)*	49	(0.8%)	*30*	*(0.8%)*	40	(0.8%)	**70**
GRAYS HARBOR CO.	*13*	*(0.3%)*	48	(0.4%)	**61**	*1*	*(0.6%)*	29	(0.5%)	*12*	*(0.3%)*	19	(0.4%)	**31**
JEFFERSON CO.	*8*	*(0.2%)*	21	(0.2%)	**29**	*3*	*(1.9%)*	14	(0.2%)	*5*	*(0.1%)*	7	(0.1%)	**12**
LEWIS CO.	*9*	*(0.2%)*	40	(0.4%)	**49**	*1*	*(0.6%)*	25	(0.4%)	*8*	*(0.2%)*	15	(0.3%)	**23**
MASON CO.	*19*	*(0.5%)*	69	(0.6%)	**88**	*0*	*(0.0%)*	20	(0.3%)	*19*	*(0.5%)*	49	(1.0%)	**68**
PACIFIC CO.	*7*	*(0.2%)*	15	(0.1%)	**22**	*0*	*(0.0%)*	9	(0.2%)	*7*	*(0.2%)*	6	(0.1%)	**13**
SKAMANIA CO.	*0*	*(0.0%)*	7	(0.1%)	**7**	*0*	*(0.0%)*	5	(0.1%)	*0*	*(0.0%)*	2	(0.0%)	**2**
THURSTON CO.	*64*	*(1.7%)*	164	(1.5%)	**228**	*2*	*(1.3%)*	75	(1.3%)	*62*	*(1.7%)*	89	(1.8%)	**151**
WAHKIAKUM CO.	*1*	*(0.0%)*	2	(0.0%)	**3**	*0*	*(0.0%)*	0	(0.0%)	*1*	*(0.0%)*	2	(0.0%)	**3**
SUBTOTAL	*1,306*	*(34.0%)*	3,856	(35.6%)	**5,162**	*73*	*(46.2%)*	2,018	(34.3%)	*1,223*	*(33.4%)*	1,838	(37.1%)	**3,071**
REGION 4 (KING) CO	*2,539*	*(66.0%)*	6,975	(64.4%)	**9,514**	*85*	*(53.8%)*	3,863	(65.7%)	*2,454*	*(66.6%)*	3,112	(62.9%)	**5,566**
STATE TOTAL	*3,845*	*(100%)*	10,831*	(100%)	**14,676**	*158*	*(100%)*	5,881**	(100%)	*3,687*	*(100%)*	4,950*	(100%)	**8,637**

1. Includes persons reported with HIV infection who are not known to have progressed to AIDS as of this report date. Does not include those who have only been tested anonymously for HIV.
8. County of residence at the time of testing positive for HIV (HIV cases) or at the time of AIDS diagnosis (AIDS cases). May not reflect where people are currently residing..

TABLE 6. WASHINGTON STATE HIV[1] CASES, YEAR OF DIAGNOSIS[3] BY GENDER, RACE/ETHNICITY,[10] EXPOSURE CATEGORY, AND AIDSNET REGION OF RESIDENCE[9] AT DIAGNOSIS, AS OF 10/31/2004

	1982-1989		1990-1997		1998-Current[5]		Cumulative		2000		2001		2002		2003[5]		2004 YTD[5]	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Gender																		
Male	396	(92%)	1,153	(84%)	1,732	(85%)	3,281	(85%)	286	(81%)	273	(87%)	269	(85%)	279	(85%)	194	(83%)
Female	35	(8%)	216	(16%)	313	(15%)	564	(15%)	66	(19%)	42	(13%)	47	(15%)	49	(15%)	39	(17%)
Total	431	(100%)	1,369	(100%)	2,045	(100%)	3,845	(100%)	352	(100%)	315	(100%)	316	(100%)	328	(100%)	233	(100%)
Race/Ethnicity[10]																		
White, not Hispanic	367	(85%)	1,058	(77%)	1,375	(67%)	2,800	(73%)	228	(65%)	214	(68%)	205	(65%)	217	(66%)	147	(63%)
Black, not Hispanic	41	(10%)	164	(12%)	345	(17%)	550	(14%)	65	(18%)	48	(15%)	67	(21%)	57	(17%)	43	(18%)
Hispanic (All Races)	11	(3%)	91	(7%)	196	(10%)	298	(8%)	39	(11%)	33	(10%)	25	(8%)	33	(10%)	22	(9%)
Asian/Pacific Islander	0	(0%)	1	(0%)	6	(0%)	7	(0%)	2	(1%)	2	(1%)	0	(0%)	0	(0%)	0	(0%)
Asian	3	(1%)	25	(2%)	57	(3%)	85	(2%)	10	(3%)	10	(3%)	7	(2%)	9	(3%)	7	(3%)
Hawaiian/Pacific Islander	1	(0%)	0	(0%)	4	(0%)	5	(0%)	1	(0%)	0	(0%)	0	(0%)	2	(1%)	0	(0%)
Native American/Alaskan	6	(1%)	21	(2%)	37	(2%)	64	(2%)	4	(1%)	5	(2%)	6	(2%)	8	(2%)	8	(3%)
Multi-race	0	(0%)	2	(0%)	11	(1%)	13	(0%)	0	(0%)	1	(0%)	4	(1%)	1	(0%)	5	(2%)
Unknown	2	(0%)	7	(1%)	14	(1%)	23	(1%)	3	(1%)	2	(1%)	2	(1%)	1	(0%)	1	(0%)
Total	431	(100%)	1,369	(100%)	2,045	(100%)	3,845	(100%)	352	(100%)	315	(100%)	316	(100%)	328	(100%)	233	(100%)
Exposure Category																		
Male/male sex (MSM)	294	(68%)	835	(61%)	1,268	(62%)	2,397	(62%)	195	(55%)	187	(59%)	197	(62%)	207	(63%)	143	(61%)
Injecting Drug Use (IDU)	46	(11%)	139	(10%)	189	(9%)	374	(10%)	47	(13%)	27	(9%)	28	(9%)	25	(8%)	21	(9%)
MSM and IDU	50	(12%)	119	(9%)	153	(7%)	322	(8%)	26	(7%)	24	(8%)	28	(9%)	26	(8%)	15	(6%)
Transfusion/Transplant	3	(1%)	7	(1%)	6	(0%)	16	(0%)	1	(0%)	2	(1%)	0	(0%)	0	(0%)	2	(1%)
Hemophilia	9	(2%)	4	(0%)	1	(0%)	14	(0%)	1	(0%)	0	(0%)	0	(0%)	0	(0%)	0	(0%)
Heterosexual Contact[6]	12	(3%)	141	(10%)	234	(11%)	387	(10%)	46	(13%)	38	(12%)	42	(13%)	39	(12%)	26	(11%)
Mother at Risk for HIV	3	(1%)	25	(2%)	7	(0%)	35	(1%)	2	(1%)	0	(0%)	0	(0%)	1	(0%)	1	(0%)
No Identified Risk[7]/Other	14	(3%)	99	(7%)	187	(9%)	300	(8%)	34	(10%)	37	(12%)	21	(7%)	30	(9%)	25	(11%)
Total	431	(100%)	1,369	(100%)	2,045	(100%)	3,845	(100%)	352	(100%)	315	(100%)	316	(100%)	328	(100%)	233	(100%)
AIDSNET Region																		
Region 1	23	(5%)	53	(4%)	86	(4%)	162	(4%)	16	(5%)	13	(4%)	15	(5%)	12	(4%)	13	(6%)
Region 2	11	(3%)	40	(3%)	73	(4%)	124	(3%)	10	(3%)	10	(3%)	15	(5%)	9	(3%)	10	(4%)
Region 3	32	(7%)	126	(9%)	141	(7%)	299	(8%)	20	(6%)	22	(7%)	16	(5%)	24	(7%)	20	(9%)
Region 5	40	(9%)	166	(12%)	218	(11%)	424	(11%)	47	(13%)	26	(8%)	36	(11%)	40	(12%)	17	(7%)
Region 6	31	(7%)	118	(9%)	148	(7%)	297	(8%)	16	(5%)	31	(10%)	25	(8%)	28	(9%)	16	(7%)
Subtotal	137	(32%)	503	(37%)	666	(33%)	1,306	(34%)	109	(31%)	102	(32%)	107	(34%)	113	(34%)	76	(33%)
Region 4 (King Co.)	294	(68%)	866	(63%)	1,379	(67%)	2,539	(66%)	243	(69%)	213	(68%)	209	(66%)	215	(66%)	157	(67%)
Total	431	(100%)	1,369	(100%)	2,045	(100%)	3,845	(100%)	352	(100%)	315	(100%)	316	(100%)	328	(100%)	233	(100%)

1 This includes persons reported with HIV infection who are not known to have progressed to AIDS as of this report date. It does not include those who have only been tested anonymously for HIV.

3 Year of diagnosis reflects the time at which disease was diagnosed by a provider. Year of report (not shown above) reflects the time at which a case report was received by the Department of Health.

5 Reporting delay is the period between the date a reportable disease is diagnosed by a physician and the date that the diagnosis is reported to public health officials. Cases counts for more recent time periods are considered to be incomplete due to reporting delays.

6 Heterosexual Contact with a person who is known to be HIV infected or at increased risk for HIV infection.

7 No Identified Risk includes patients for whom risk information is incomplete, cases still under investigation, and interviewed patients with no recognized HIV exposure category.

9 AIDSNET Region of residence at the time of testing positive for HIV (HIV cases) or at the time of AIDS diagnosis (AIDS cases). May not reflect where people are currently residing.

10 Collection and presentation of race/ethnicity data have been adjusted to be consistent with Census 2000 data collection and presentation methods. Consequently, data for Asian/Pacific Islanders are now collected and presented in two separate categories ("Asian" and "Hawaiian/Pacific Islander"), while historical data are presented in the "Asian/Pacific Islander" category. Those who report more than one race are presented in the "Multi-race" category.

TABLE 7. WASHINGTON STATE AIDS CASES, YEAR OF DIAGNOSIS[3] BY GENDER, RACE/ETHNICITY,[10] EXPOSURE CATEGORY, AND AIDSNET REGION OF RESIDENCE[9] AT DIAGNOSIS, AS OF 10/31/2004

	1982-1989		1990-1997		1998-Current[5]		Cumulative		2000		2001		2002		2003[5]		2004 YTD[5]	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Gender																		
Male	1,899	(97%)	5,693	(92%)	2,310	(86%)	9,892	(91%)	369	(86%)	354	(88%)	364	(83%)	363	(84%)	212	(82%)
Female	62	(3%)	493	(8%)	384	(14%)	939	(9%)	62	(14%)	48	(12%)	72	(17%)	69	(16%)	46	(18%)
Total	1,979	(100%)	6,472	(100%)	2,745	(100%)	11,196	(100%)	453	(100%)	416	(100%)	435	(100%)	432	(100%)	221	(100%)
Race/Ethnicity[10]																		
White, not Hispanic	1,710	(88%)	4,918	(80%)	1,796	(67%)	8,424	(78%)	293	(68%)	263	(65%)	281	(64%)	280	(65%)	173	(67%)
Black, not Hispanic	130	(7%)	605	(10%)	449	(17%)	1,184	(11%)	77	(18%)	73	(18%)	79	(18%)	68	(16%)	43	(17%)
Hispanic (All Races)	75	(4%)	417	(7%)	296	(11%)	788	(7%)	42	(10%)	46	(11%)	46	(11%)	56	(13%)	24	(9%)
Asian/Pacific Islander	3	(0%)	31	(1%)	11	(0%)	45	(0%)	0	(0%)	3	(1%)	4	(1%)	1	(0%)	0	(0%)
Asian	11	(1%)	68	(1%)	46	(2%)	125	(1%)	3	(1%)	5	(1%)	12	(3%)	10	(2%)	5	(2%)
Hawaiian/Pacific Islander	5	(0%)	9	(0%)	12	(0%)	26	(0%)	3	(1%)	0	(0%)	2	(0%)	5	(1%)	2	(1%)
Native American/Alaskan	16	(1%)	118	(2%)	64	(2%)	198	(2%)	8	(2%)	10	(2%)	11	(3%)	9	(2%)	7	(3%)
Multi-race	1	(0%)	17	(0%)	10	(0%)	28	(0%)	2	(0%)	0	(0%)	0	(0%)	3	(1%)	4	(2%)
Unknown	0	(0%)	3	(0%)	10	(0%)	13	(0%)	3	(1%)	2	(0%)	1	(0%)	0	(0%)	0	(0%)
Total	1,951	(100%)	6,186	(100%)	2,694	(100%)	10,831*	(100%)	431	(100%)	402	(100%)	436	(100%)	432	(100%)	258	(100%)
Exposure Category																		
Male/male sex (MSM)	1,500	(77%)	4,227	(68%)	1,508	(56%)	7,235	(67%)	246	(57%)	235	(58%)	234	(54%)	244	(56%)	135	(52%)
Injecting Drug Use (IDU)	83	(4%)	574	(9%)	326	(12%)	983	(9%)	54	(13%)	44	(11%)	50	(11%)	48	(11%)	30	(12%)
MSM and IDU	232	(12%)	607	(10%)	227	(8%)	1,066	(10%)	33	(8%)	35	(9%)	39	(9%)	31	(7%)	21	(8%)
Transfusion/Transplant	47	(2%)	64	(1%)	11	(0%)	122	(1%)	3	(1%)	0	(0%)	1	(0%)	1	(0%)	2	(1%)
Hemophilia	30	(2%)	52	(1%)	8	(0%)	90	(1%)	3	(1%)	1	(0%)	0	(0%)	1	(0%)	1	(0%)
Heterosexual Contact[6]	29	(1%)	372	(6%)	327	(12%)	728	(7%)	48	(11%)	51	(13%)	70	(16%)	55	(13%)	39	(15%)
Mother at Risk for HIV	8	(0%)	18	(0%)	2	(0%)	28	(0%)	2	(0%)	0	(0%)	0	(0%)	0	(0%)	0	(0%)
No Identified Risk[7]/Other	22	(1%)	272	(4%)	285	(11%)	579	(5%)	42	(10%)	36	(9%)	42	(10%)	52	(12%)	30	(12%)
Total	1,951	(100%)	6,186	(100%)	2,694	(100%)	10,831*	(100%)	431	(100%)	402	(100%)	436	(100%)	432	(100%)	258	(100%)
AIDSNET Region																		
Region 1	79	(4%)	343	(6%)	175	(6%)	597	(6%)	32	(7%)	19	(5%)	30	(7%)	27	(6%)	17	(7%)
Region 2	48	(2%)	192	(3%)	123	(5%)	363	(3%)	17	(4%)	18	(4%)	15	(3%)	22	(5%)	17	(7%)
Region 3	111	(6%)	515	(8%)	227	(8%)	853	(8%)	26	(6%)	30	(7%)	42	(10%)	40	(9%)	20	(8%)
Region 5	171	(9%)	645	(10%)	330	(12%)	1,146	(11%)	69	(16%)	58	(14%)	40	(9%)	37	(9%)	33	(13%)
Region 6	108	(6%)	532	(9%)	257	(10%)	897	(8%)	33	(8%)	52	(13%)	50	(11%)	30	(7%)	31	(12%)
Subtotal	517	(26%)	2,227	(36%)	1,112	(41%)	3,856	(36%)	177	(41%)	177	(44%)	177	(41%)	156	(36%)	118	(46%)
Region 4 (King Co.)	1,434	(74%)	3,959	(64%)	1,582	(59%)	6,975	(64%)	254	(59%)	225	(56%)	259	(59%)	276	(64%)	140	(54%)
Total	1,951	(100%)	6,186	(100%)	2,694	(100%)	10,831	(100%)	431	(100%)	402	(100%)	436	(100%)	432	(100%)	258	(100%)

3 Year of diagnosis reflects the time at which disease was diagnosed by a provider. Year of report (not shown above) reflects the time at which a case report was received by the Department of Health.

5 Reporting delay is the period between the date a reportable disease is diagnosed by a physician and the date that the diagnosis is reported to public health officials. Cases counts for more recent time periods are considered to be incomplete due to reporting delays.

6 Heterosexual Contact with a person who is known to be HIV infected or at increased risk for HIV infection

7 No Identified Risk includes patients for whom risk information is incomplete, cases still under investigation, and interviewed patients with no recognized HIV exposure category.

9 AIDSNET Region of residence at the time of testing positive for HIV (HIV cases) or at the time of AIDS diagnosis (AIDS cases). May not reflect where people are currently residing.

10 Collection and presentation of race/ethnicity data have been adjusted to be consistent with Census 2000 data collection and presentation methods. Consequently, data for Asian/Pacific Islanders are now collected and presented in two separate categories ("Asian" and "Hawaiian/Pacific Islander"), while historical data are presented in the "Asian/Pacific Islander" category. Those who report more than one race are presented in the "Multi-race" category.

* For explanation of revised AIDS total, see technical notes

WASHINGTON STATE REPORTED CASES OF CHLAMYDIA, GONORRHEA, EARLY SYPHILIS, JANUARY - SEPTEMBER 2004

	Chlamydia		Gonorrhea		Early Syphilis	
Sex	**No.**	**(%)**	**No.**	**(%)**	**No.**	**(%)**
Male	3,611	(27.3)	1,137	(55.7)	141	(97.2)
Female	9,604	(72.7)	903	(44.3)	4	(2.8)
TOTAL	**13,215**	**(100.0)**	**2,040**	**(100.0)**	**145**	**(100.0)**
Age						
0-14	183	(1.4)	24	(1.2)	0	(0.0)
15-19	4,312	(32.6)	405	(19.9)	0	(0.0)
20-24	5,027	(38.0)	535	(26.2)	9	(6.2)
25-29	1,971	(14.9)	318	(15.6)	19	(13.1)
30-34	801	(6.1)	242	(11.9)	30	(20.7)
35-39	402	(3.0)	206	(10.1)	37	(25.5)
40+	382	(2.9)	299	(14.7)	50	(34.5)
Unknown	137	(1.0)	11	(0.5)	0	(0.0)
TOTAL	**13,215**	**(100.0)**	**2,040**	**(100.0)**	**145**	**(100.0)**
Ethnic/Race						
White	6,140	(46.5)	867	(42.5)	80	(55.2)
Black	1,692	(12.8)	453	(22.2)	27	(18.6)
Hispanic	1,961	(14.8)	228	(11.2)	18	(12.4)
Native Hawaiian/Other Pacific Islander	139	(1.1)	10	(0.5)	0	(0.0)
Asian	518	(3.9)	47	(2.3)	8	(5.5)
Native American	399	(3.0)	64	(3.1)	3	(2.1)
Multi	384	(2.9)	47	(2.3)	2	(1.4)
Other	76	(0.6)	8	(0.4)	0	(0.0)
Unknown	1,906	(14.4)	316	(15.5)	7	(4.8)
TOTAL	**13,215**	**(100.0)**	**2,040**	**(100.0)**	**145**	**(100.0)**

Provider Type	**Cases**	**# Prov**	**Cases**	**# Prov**	**Cases**	**# Prov**
Community Health Ctr.	412	34	104	20	11	2
Emergency Care (Not Hosp.)	232	46	72	26	1	1
Family Planning	2,945	55	211	34	0	0
Health Plan/HMO's	393	39	61	25	4	3
Hospitals	1,144	86	276	50	9	4
Indian Health	169	20	27	9	2	2
Jail/Correction/Detention	511	37	97	17	5	1
Migrant Health	441	22	59	14	2	2
Military	547	9	58	7	4	3
Neighborhood Health	96	14	16	7	0	0
OB/GYN	851	101	67	40	0	0
Other	2,639	524	404	215	45	19
Private Physician	308	139	51	32	22	7
Reproductive Health	1,034	18	99	15	1	1
STD	983	29	398	12	39	3
Student Health	510	26	40	12	0	0
TOTAL	**13,215**	**1,199**	**2,040**	**535**	**145**	**48**

WASHINGTON STATE REPORTED STDS BY COUNTY JANUARY - JUNE 2004

	CT	GC	HERPES	P & S	EL	L/LL	CONG	TOTAL
Adams	16	2	0	0	0	0	-	0
Asotin	30	1	7	0	0	0	-	0
Benton	298	14	33	0	0	1	-	1
Chelan	122	2	22	0	0	2	-	2
Clallam	109	8	20	2	1	1	-	2
Clark	647	126	30	2	2	0	-	4
Columbia	7	0	0	0	0	0	-	0
Cowlitz	151	27	11	0	0	3	-	3
Douglas	63	2	8	0	0	0	-	0
Ferry	11	0	3	0	0	0	-	0
Franklin	139	3	7	0	0	0	-	0
Garfield	0	0	0	0	0	0	-	0
Grant	191	13	21	0	0	0	-	0
Grays Harbor	149	3	7	0	0	0	-	0
Island	144	9	27	1	0	1	-	2
Jefferson	25	3	8	0	0	0	-	0
King	4,037	899	553	84	30	50	-	164
Kitsap	478	44	38	3	2	0	-	5
Kittitas	64	0	8	0	0	0	-	0
Klickitat	35	5	3	0	0	0	-	0
Lewis	160	8	13	0	0	0	-	0
Lincoln	7	0	0	0	0	0	-	0
Mason	85	5	13	0	0	0	-	0
Okanogan	108	3	11	0	0	1	-	1
Pacific	32	1	3	0	0	0	-	0
Pend Oreille	10	1	4	0	0	0	-	0
Pierce	2,130	341	152	5	1	9	-	15
San Juan	17	0	4	0	0	0	-	0
Skagit	207	12	43	1	0	0	-	1
Skamania	16	2	1	0	0	0	-	0
Snohomish	1,161	128	173	5	3	8	-	16
Spokane	815	117	122	0	0	4	-	4
Stevens	36	1	6	0	0	0	-	0
Thurston	384	32	43	2	0	2	-	4
Wahkiakum	2	0	0	0	0	0	-	0
Walla Walla	101	5	16	0	0	0	-	0
Whatcom	352	55	71	0	0	2	-	2
Whitman	105	6	7	0	0	0	-	0
Yakima	771	161	105	0	2	9	-	11
YEAR TO DATE	13,215	2,040	1,594	104	41	98	0	243
PRV YR TO DATE	12,267	2,060	1,484	58	34	88	0	180
% CHANGE	7.7%	-1.0%	7.4%	79.3%	20.6%	11.4%	NC	35.0%

CT = Chlamydia Trachomatis
GC = Gonorrhea
HERPES = Initial Genital Herpes
P/S = Primary & Secondary Syphilis
EL = Early Latent Syphilis
L/LL = Late/Late Latent Syphilis
CONG = Congenital Syphilis

MONTHLY TUBERCULOSIS CASE TOTALS BY COUNTY, 2003-2004

	JAN		FEB		MAR		APR		MAY		JUN		JUL		AUG		SEP		OCT		NOV		DEC		TOTAL	
COUNTY	2003	2004	2003	2004	2003	2004	2003	2004	2003	2004	2003	2004	2003	2004	2003	2004	2003	2004	2003	2004	2003	2004	2003	2004	2003	2004
Adams					1																				**1**	**0**
Asotin																									**0**	**0**
Benton				1						2			1							1			1		**2**	**4**
Chelan					1								3												**4**	**0**
Clallam	1																								**1**	**0**
Clark							1	1		1	1	2			4				1	1	3		1		**10**	**5**
Columbia																									**0**	**0**
Cowlitz													1												**1**	**0**
Douglas					1		1																		**2**	**0**
Ferry																									**0**	**0**
Franklin				1	1		1			1			2			1									**5**	**3**
Garfield																									**0**	**0**
Grant							2												1						**3**	**0**
Grays Harbor	1																								**1**	**0**
Island	1									1				1				2							**1**	**4**
Jefferson																									**0**	**0**
King	10	8	14	12	12	7	17	15	14	6	3	19	20	20	18	5	13	11	10	9	9		15		**155**	**112**
Kitsap									1					1									1		**2**	**1**
Kittitas								1																	**0**	**1**
Klickitat																									**0**	**0**
Lewis				1															1				1		**2**	**1**
Lincoln																									**0**	**0**
Mason			1		1																		1		**3**	**0**
Okanogan									1				1												**2**	**0**
Pacific																									**0**	**0**
Pend-Oreille																									**0**	**0**
Pierce	1	1	1	2		1	2	2	1	1		9	2	1	2	4	1	2	4	1	2		2		**18**	**24**
San Juan																		1							**0**	**1**
Skagit												1					1		1	1					**2**	**2**
Skamania																									**0**	**0**
Snohomish	3				2		1			1		2	1	1	1	2	2	2		5			2		**12**	**13**
Spokane		3		1	1	1							3	1											**4**	**6**
Stevens																									**0**	**0**
Thurston				1			1			1		1	1					1		3			3		**5**	**7**
Wahkiakum																									**0**	**0**
Walla Walla							1													1					**1**	**1**
Whatcom		1				1	1	1	1			1	1							2	1		1		**5**	**6**
Whitman																									**0**	**0**
Yakima	1	2		3		1		1		1	2		2	1				2	1	1	1		1		**8**	**12**
State Total	**18**	**15**	**16**	**22**	**20**	**11**	**28**	**21**	**18**	**15**	**6**	**35**	**38**	**26**	**25**	**12**	**17**	**21**	**19**	**25**	**16**	**0**	**29**	**0**	**250**	**203**
YTD State Total	**18**	**15**	**34**	**37**	**54**	**48**	**82**	**69**	**100**	**84**	**106**	**119**	**144**	**145**	**169**	**157**	**186**	**178**	**205**	**203**	**221**	**203**	**250**	**203**	**250**	**203**

Note: Detailed analysis of tuberculosis morbidity is contained in "Washington State Tuberculosis Epidemiological Profile - 1998" and is available to order from the State TB Program by calling (360) 236-3443.

Deadline Details For *Washington State Responds* Quarterly Newsletter

The deadline for the next issue of ***Washington State Responds*** is **December 20, 2004**. The calendar start date for the issue is **February 5, 2005**. To submit information, corrections, or to be added or dropped from the mailing list, contact Barbara Schuler, Washington State Department of Health, HIV Prevention and Education Services, P.O. Box 47840, Olympia, WA 98504-7840. You may also telephone her at: (360) 236-3487 or call the Washington State Hotline at **1-800-272-2437, ext. 0** to leave a message**.** You may fax your information to (360) 236-3400, or preferably send via e-mail to:**barbara.schuler@ doh.wa.gov**

We greatly appreciate news of your work or your organization!

Thank you for taking the time and effort to write, call, fax or e-mail!

DOH HIV/AIDS Prevention and Education Services

Washington State Department of Health HIV/AIDS Prevention and Education Services publishes information in this quarterly newsletter, ***Washington State Responds,*** as a courtesy to our readers, however, inclusion of information coming from outside of the Washington State Department of Health does not necessarily imply endorsement by the Washington State Department of Health.

The content of this newsletter is for informational purposes only and is not intended to be a substitute for professional medical advice, diagnosis or treatment.

This newsletter may contain HIV prevention messages that may not be appropriate for all audiences. Since HIV infection is spread primarily through sexual practices or by sharing syringe needles, prevention messages and programs may address these topics. If you are not seeking such information or are offended by such materials, do not visit this site.